Integrated Health Project in Burundi (IHPB)
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Quarterly Report
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Acronyms and Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ABUBEF	*Association Burundaise pour le Bien Etre Familial*
ACTs	Artemisinin-based Combination Therapy
ADBC	*Agent Distributeur à Base Communautaire* (Community Based Distributor of Contraceptives)
AMTSL	Active Management of the Third Stage of Labor
ANC	Antenatal Care
ANSS	*Association Nationale de Soutien aux Séropositifs et aux Sidéens*
ART	Anti-Retroviral Therapy
BCC	Behavior Change Communication
BDS	*Bureau du District Sanitaire* (District Health Bureau)
BEmONC	Basic Emergency Obstetric and Neonatal Care
BMCHP	Burundi Maternal and Child Health Project
BPS	*Bureau Provincial de la Santé* (Provincial Health Bureau)
BRAVI	Burundians Responding Against Violence and Inequality
BTC	Belgian Technical Cooperation
CAM	*Carte d'Assistance Médicale* (Health Assistance Card)
CBO	Community-Based Organization
C-Change	Communication for Change
CCM	Community case management
CCT	Community Conversation Toolkit
CFR/OMB	Code of Federal Regulations/Office of Management and Budget
CHW	Community Health Worker
COGES	*Comité de gestion* ([health] management committee)
COP	Chief of Party
COSA	*Comité de Santé* (health committee)
CPSD	*Cadre de Concertation pour la Santé et le Développement*
CPVV	*Comité Provincial de Vérification et de Validation*
CS	Capacity Strengthening
CSO	Civil Society Organization
CTN	*Cellule Technique Nationale*
CT FBP	*Cellule technique du Financement Basé sur la Performance*
DATIM	Data for Accountability, Transparency and Impact
DCOP	Deputy Chief of Party
DHE	District Health Educator
DHIS	District Health Information System
DHS	Demographic and Health Survey
DHT	District Health Team
DPE	*Direction Provinciale de l'Enseignement*
DPSHA	*Département de Promotion de la Santé, Hygiène et Assainissement* (Department of Health, Hygiene and Sanitation)
DQA	Data Quality Assurance
EC	Emergency Contraception
EID	Early Infant Diagnostic
EONC	Emergency Obstetric and Neonatal Care

ENA	Emergency Nutrition Assessment
FAB	Formative Analysis and Baseline Assessment
FGD	Focus Group Discussion
FHI 360	Family Health International
FFP	Flexible Family Planning Project
FP	Family Planning
FQA	Facility Qualitative Assessment
FTO	Field Technical Officer
GASC	Groupement d'Agents de Santé communautaire
GBV	Gender-based violence
GESIS	*Gestion du système d'information sanitaire (*national health information system)
GoB	Government of Burundi
HBC	Home-Based Care
HD	Health District
HealthNet TPO	Dutch aid agency – merger between HealthNet International and Transcultural Psychosocial Organization
HH	Household
HIV	Human Immunodeficiency Virus
HPT	Health Promotion Technician
HIS	Health Information System
HQ	Headquarters
HR	Human Resources
HRH	Human Resources for Health
HSS	Health Systems Strengthening
HTC	HIV Testing and Counseling
iCCM	Integrated Community Case Management
IDI	In-Depth Interview
IHPB	Integrated Health Project in Burundi
IKG	In kind grants
INGO	International Non-Governmental Organizations
IP	Implementing Partner
IIP	Institutional Improvement Plan
IPTp	Intermittent Preventive Treatment of malaria during Pregnancy
IPC	Interpersonal Communication
IRB	Institutional Review Board
ISTEEBU	*Institut de Statistiques et d'Etudes Economiques du Burundi*
ITN	Insecticide-Treated Net
IYCF	Infant Young Child Feeding
JICA	Japanese International Cooperation Agency
Kfw	Kreditanstalt für Wiederaufbau (Établissement de crédit pour la reconstruction) Allemand (German Development Bank)
KII	Key Informant Interview
LLIN	Long Lasting Insecticide Treated Nets
LMIS	Logistics Management Information System
LOE	Level of Effort
LOP	Life of Project
LPT	Local Partner Transition

M&E	Monitoring and Evaluation
MARPs	Most at Risk Populations
MCH	Maternal and Child Health
MNCH	Maternal, Neonatal and Child Health
MoU	Memorandum of Understanding
MPHFA	Ministry of Public Health and the Fight against AIDS
MSH	Management Sciences for Health
MUAC	Mid-Upper Arm Circumference
NHIS	National Health Information System
NPAC	National Program for AIDS/STIs Control
NMCP	National Malaria Control Program
NGO	Non-Governmental Organization
OIRE	Office of International Research Ethics
OVC	Orphans and Vulnerable Children
PBF	Performance-Based Financing
PCI	Population Communications International
PCR	Polymerase Chain Reaction
PECADOM	*Prise en Charge à domicile* (Community case Management)
PEP	Post-Exposure Prophylaxis
PEPFAR	US President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PMC	Population Media Center
PMEP	Performance Monitoring & Evaluation Plan
PMTCT	Prevention of Mother-to-Child Transmission
PNILP	*Programme National Intégré de Lutte contre le Paludisme*
PNSR	*Programme National de Santé de la Reproduction*
PPP	Public-Private Partnership
PSI	Population Services International
QA/QI	Quality Assurance/Quality Improvement
QA	Quality Assurance
QI	Quality Improvement
QIT	Quality improvement team
RBP+	*Réseau Burundais des Personnes vivant avec le VIH*
RDTs	Rapid Diagnostic Tests
RH	Reproductive Health
ROADS II	Roads to a Healthy Future
SARA	Services Availability and Readiness Assessment
SDPs	Service Delivery Points
SBC	Strategic Behavior Change
SBCC	Social and Behavior Change Communication
SCM	Supply Chain Management
SCMS	Supply Chain Management System
SDA	Small Doable Action
SGBV	sexual and gender-based violence
SIAPS	System for Improved Access to Pharmaceuticals and Services
SIMS	Site Improvement through Monitoring System
SLT	Senior Leadership Team

SMS	Short Message Service
SOP	Standard Operating Procedures
SRH	Sexual and Reproductive Health
STA	Senior Technical Advisor
STI	Sexually Transmitted Infection
STTA	Short-Term Technical Assistance
SWAA	Society for Women against AIDS in Africa
TA	Technical Assistance
TB	Tuberculosis
TOR	Terms of Reference
ToT	Training of Trainers
TWG	Technical Working Group
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
USAID	United States Agency for International Development
USG	United States Government
URC	University Research Corporation
VMMC	Voluntary Medical Male Circumcision
WHO	World Health Organization
WP	Work Plan
Y2	Project Year 2

Introduction

The *Integrated Health Project in Burundi* (IHPB) is a five-year (December 23, 2013 to December 22, 2018) project funded by the United States Agency for International Development (USAID). IHPB builds on USAID's legacy of support to the health sector in Burundi and FHI 360 and Pathfinder's successes in assisting the Government of Burundi (GoB) to expand and integrate essential services for: HIV/AIDS; maternal, neonatal and child health (MNCH); malaria; family planning (FP); and reproductive health (RH).

The Ministry of Public Health and Fight against AIDS (MPHFA) is a major partner that is involved at every step throughout project planning and implementation. IHPB's goal is to assist the GoB, communities, and civil society organizations (CSOs) to improve the health status of populations in 12 health districts located in the provinces of Karusi, Kayanza, Kirundo, and Muyinga. IHPB's expected results are:

1) Increased positive behaviors at the individual and household levels;
2) Increased use of quality integrated health and support services; and
3) Strengthened health system and civil society capacity.

This quarterly report details program activities during the period from April 1, 2016 to June 30, 2016. Highlights of the achievements are presented below:

- Established with the MPHFA a social and behavior change (SBCC) Stakeholder Working Group;
- Developed and pre-tested three sets of communication materials for pregnant women, adolescents and young adults and submitted for review by the SBCC Stakeholder Working Group;
- Developed first draft of Community Mobilization Guide;
- Provided essential tools and supplies to community health workers (CHWs) implementing community case management (CCM) of malaria in four health districts;
- Conducted two two-day training sessions on gender-integrated approaches and trained 45 (20 female and 25 male) health care workers from pediatrics, HIV, maternity, antenatal care, family planning and health information systems units of nine partner hospitals in IHPB intervention provinces;
- In addition, the IHPB Maternal and Child Health Specialist and Muyinga Field Office Manager were trained as national trainers on gender based violence (GBV) in a training that was organized by the National Reproductive Health Program (PNSR) in partnership with the USAID-funded Burundians Responding Against Violence and Inequality (BRAVI) project;
- conducted a 4-day training of trainers of CHWs on the care of acute malnutrition at community level whereby 19 (5 female and 14 male) were trained as trainers, in partnership with the central MPHFA;
- Conducted 5-day training sessions attended (in separate parallel sessions) by 187 CHWs (75 female and 112 male), on the community component of integrated management of childhood illness (IMCI) and on the standard community reporting tool, in partnership with Nyabikere health district office;
- Conducted three five-day mentoring visits with district supervisors trained in coaching QI teams in partnership with respective provinces and health district
- Completed data cleaning and conducted preliminary analysis of the IHPB's training activities and trainee records for Y2 and Y3 through April 2016;
- Trained 994 on the use of standard report form and supported (funding through sub-grants) 7 district-led data analysis workshops;

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- Following approval by USAID, signed an amendment of the ANSS sub-agreement and started discussions with SWAA Burundi and RBP+ for eventual amendment of sub-agreements;
- Organized three three-day training sessions for 61 (36 males and 25 female) participants from Gahombo (39) and Musema (22) on active management of the third stage of labor (AMTSL);
- Organized a ten-day training of trainer's session on *EONC* for 15 people (14 males and 1 female) from Karusi (6) and Muyinga (9);
- Organized a monthly meeting of community based distributors of contraceptives (CBDCs) attended by 137 CBDCs (78 males and 59 female) from three health centers of Muyinga district: Rubagano (28), Mwakiro (42), and Bonero (24);
- Participated in the week-long Maternal and Child Health Week in the four IHPB provinces – attended daily organizational meetings with provincial and national health authorities; assisted with transportation and distribution of inputs (vaccines, Vitamin A and other commodities); and supervision and evaluation of activities;
- Key HIV/AIDS activities implemented were: (a) Supported two five-day training sessions on management of TB and HIV attended by 81 health workers (49 male and 32 female) from Kayanza, Musema and Gahombo hospitals; (b) Organized two five-day workshop on HIV testing and counseling attended by 50 (31 male and 19 female) health care workers; (c) Through RBP+ grant, a total of 198 (104 male and 94 female) orphans and vulnerable children (OVC) were tested and 15 found positive; (d) Supported 95 prevention of mother-to-child (PMTCT) sites (46 in Kirundo and 49 in Kayanza) to offer ARVs; (e) Transported 261 DBS and 457 viral load samples from health facilities to a National Reference Laboratory (INSP); (f) 1,137 OVC (469 male and 648 female) were received various forms of assistance; and (g) 2,178 CD4 cell count samples were examined and those with CD 4 count less than 500 were placed on ART;
- Organized a five-day internship for 205 CHWs that were trained on community case management (CCM) of malaria in the Musema health district; (b) Malaria Specialist attended four coordination meetings;
- Conduced an intensive two-week long Program and Technical Assessment whose objective was to collaboratively explore and identify essential means to strengthen the project and technical quality of the IHPB;
- Identified a Chief of Party and sought and obtained USAID concurrence to hire the COP. COP scheduled to report in-country in August 2016; and
- Attended various meetings organized by the MPHFA. These included: the Maternal Health Specialist participated in regional (Burundi) workshops on maternal death surveillance organized by the PNSR; IHPB Malaria specialist participated in four meetings organized by the Department of Demand and Offer of Healthcare Services of the MPHFA and UNICEF to discuss how to expand integrated community case management (iCCM) in health districts where community case management (CCM) of malaria is being implemented; Capacity Building Officer represented IHPB at series of meetings in preparation for week-long Maternal and Child Health Week; Gahombo District Program Officer represented IHPB at the 6th African Vaccination Week event - mobilization (in Ngozi) and launching (in Gitega) under the slogan, "Closing the Gaps – Vaccinated Community = Healthy Community".

CLIN 1: Increased Positive Behaviors at the Individual, Household and Community Levels

Sub-CLIN 1.1: Improved key behavioral pre-determinants at the individual, household and community levels

	Planned for April-June 2016	Achievement and results	Comments
Establish SBCC Stakeholder Working Group	Convene at least four working group sessions	Working group is in place	First working group session scheduled for August 2016
	Provide Working Group draft IHPB SBCC messages and materials, solicit feedback and incorporate		Planned for August 2016
Develop campaign and materials using Life Stage Approach	Produce first draft of SBCC materials for Life Stage II	Achieved	Three sets of communication materials developed
	Pre-test Life Stage II materials	Achieved	
Strengthen MPHFA Capacity in SBCC	Convene three-day C-Module session with MPHFA staff		Scheduled for July 2016
Community mobilization	Train 65 HPTs on community mobilization	Community mobilization guide adapted	Training scheduled for July – September quarter
	Meet with local leaders and community actors in each of 12 districts to monitor and support implementation of action plans	In progress	Subsequent to community mobilization plan implementation
Develop and air radio serial drama that reinforces IPC and community mobilization efforts	Record and pre-test pilot episode	Design document developed	Contract signed with PCI Media Impact to produce serial drama
	Analyze and incorporate pre-test results		Outline of radio programming produced
	Develop episodes 1-6	In progress	
	Produce, edit and broadcast Episodes 1-6		Planned for July – September quarter

During the reporting period, the SBCC section planned to continue activities that are in line with our strategic framework. The key activities are: 1) establish an SBCC stakeholders working group; 2) continue developing materials using the life stage approach; 3) strengthen the capacity of the Ministry of Health in the SBCC area; 4) develop a community mobilization guide; and 5) develop a serial radio drama as part of a mass media approach to reinforce other communication interventions.

Key achievements for the quarter April– June 2016 are as follows:

Establish SBCC Stakeholder Working Group

IHPB received the authorization letter from the MPHFA to start the first meeting of the SBCC Stakeholder Working Group which would enable strengthen the efforts carried out by various organizations and at the same time, enhance the collaboration, communication, coordination across the organizations. Population Services International (PSI), Population Media Center (PMC), Search for Common Ground, and the Department of Health, Hygiene and Sanitation (DPSHA) were selected for their expertise in health communication as members of the technical working group. IHPB will organize the first meeting sessions

in the next quarter. This will be an opportunity for members to undertake peer-to-peer review for the three sets of communication materials developed by the IHPB.

Develop campaign and materials using the Life Stage Approach

Three sets of communication materials for pregnant women, adolescents and young adults have been developed. Key messages for pregnant women are on intermittent preventive treatment of malaria during pregnancy (IPTp), antenatal care (ANC), prevention of mother-to-child transmission (PMTCT) of HIV/AIDS, long-lasting insecticide treated net (LLIN) use, reduction of exhaustive work, birth preparedness and delivery at a health facility, danger signs of pregnancy.

The key messages for young adults are based on sexual and reproductive health (SRH), HIV/AIDS prevention and testing, delay sexual debut, sexual and reproductive health information seeking from trusted sources, and condom use and male circumcision.

The three sets of materials have been pre-tested with their respective target audiences; A series of three focus group discussions of 10 to 14 participants were organized in Kirundo and two focused group discussions with 14 participants were organized in Kayanza provinces to so that target audience members could provide feedback across five key SBCC areas: comprehension of the material's message; attractiveness of the illustrations; acceptance of the messages by the target audience; involvement; and whether the material/activity induces action. After the consultation, modifications were made to made to meet expectations, appropriateness, and ownership of the materials.

In next steps, the materials will be reviewed in terms of technical content and presentation by members of the SBCC Stakeholders Working Group.

Strengthen MPHFA capacity in SBCC

To contribute to the MPHFA's ability to implement SBCC at the community level, IHPB hired an external consultant to finalize the SBCC training curriculum module that was in a draft form; the consultant also completed preparations for an SBCC training workshop. The modification aimed to achieve an appropriate balance between the material presented in the C-Change modules and practical field session.

The SBCC training module helps trainees to: practice undertaking a root cause analysis using existing data from Demographic and Health Survey Burundi; identify a small doable action that can be carried out by the community, and conduct an "Action Inquiry," in focus groups with the community to narrow down the lists of small doable actions, and conduct role play that will help practitioners to negotiate the identified small do able action with the community.

The training is planned for July 2016 in Kayanza to train 20 MPHFA DPHSA staff from the central and provincial levels so that they will have strengthened capacity to conduct SBCC activities.

Train community mobilization

The SBCC team developed the first draft of the Community Mobilization Guide, which provides Health Promotion Technicians (HPTs) with mobilization strategies and techniques on how to identify public health problems and develop appropriate strategies to address them. The Community Mobilization Guide

has been subject of practical inputs as suggested by the SBCC Consultant with more focus on small doable actions and building on successful individuals, known as « étoiles brillantes », or shining stars, to serve as a community model for behavior change. The Community Mobilization Guide is under adaptation; it will be deployed at trainings scheduled for the quarter July – September 2016.

Implement mobile cinema in the Gashoho health district

IHPB used mobile cinema in the Gashoho health district to promote healthy community behaviors and the uptake of health services for improved maternal, neonatal, and child health. Messages focused on: the importance of seeking early (first trimester) antenatal care and planning for an assisted-delivery in a facility; long lasting insecticide treated net use; and exclusive breastfeeding for six months. The mobile cinema reached an estimated 860 people (750 females and 110 male) at three sites (Nyungu, Gashoho and Kiremba). This activity is entertaining for community members and creates a platform to discuss ways to address barriers to adopting these healthy behaviors and seeking care at the facility.

Develop and air radio serial drama that reinforces interpersonal communication (IPC) and community mobilization efforts

Following an open tender process, IHBP retained the services of Population Communications International (PCI) Media Impact to produce and disseminate a serial radio drama to reinforce community health mobilization efforts described above. A contract has been signed with FHI360. PCI Media Impact has started identifying a national production house that will help to recruit local actors and engage a local production unit. A design document has been developed and an expanded outline of the radio programming has been produced with dedicated time allocated to the drama followed by dialogue between listeners and the guest and/or listeners. PCI Media Impact will work with the identified local house to record and pretest the first two episodes of the drama in the next quarter.

Progress and discussion on SBCC indicators

Indicator	**Target FY2016**	**Achieved to date FY 2016**				
		Oct-Dec 2015	Jan-March 2016	April 2016	May 2016	Total
1.0.1. Percent of the targeted audiences who report practicing positive behaviors at the individual and household levels [Mandatory Result]	N/A[1]					
1.1.1Percent of the targeted audiences who report key behavioral pre-determinants at the individual, household, and community levels [Mandatory Result]	N/A					
1.1.2. Percent of targeted population who correctly report causes of specific illness (e.g. HIV/AIDS; malaria; diarrhea) [Mandatory Result]	N/A					

[1] Outcomes indicators will be measured with the endline survey

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec 2015	Jan-March 2016	April 2016	May 2016	Total
1.1.3. Percent of the target population who recall hearing or seeing or reading a specific HC message	N/A					
1.1.4 Number of health communication materials developed, field tested, and disseminated for use	4	1	13	10		21

1.0.1. Percent of the targeted audiences who report practicing positive behaviors at the individual and household levels [Mandatory Result]

The 5 indicators under 1.0.1, for which base lines was established (Household Survey) for are:

- Percent of women who report delivering in a health facility for their last pregnancy
- The percent of women seen by a health provider within the first 48 hours following delivery
- Percent of children who were exclusively breastfed until 6 months of age
- Percent of women who are using a modern method of contraception
- Percent of pregnant women who report having slept under an ITN the previous night

Progress on the aforementioned indicators will be measured by the end line survey

1.1.1. Percent of the targeted audiences who report key behavioral pre-determinants at the individual, household, and community levels [Mandatory Result]

The 14 indicators under 1.1.1, for which baselines were established (Household Survey) are:

- % of women and men who are married/cohabitating that report that their spouse and they make decisions on how many children you as a couple should have.
- % of women and men who have heard of 3 or more modern FP methods.
- % of women and men who believe that young women (aged 13-18 years) should use FP methods if they choose to do so.
- Average number of risks of FP methods use identified by women.
- % of women who delivered in a health facility that would recommend a sister or friend to deliver at the health facility.
- % of women who delivered in a health facility that would choose to deliver at the health facility for her next delivery.
- % of men that considers the health of a pregnant women and/or child an emergency
- % of women who identified 3 or more benefits of breastfeeding
- % of women who agreed with 3 or more of four positive attitudes towards breastfeeding
- % of women who are able to get good advice from a health care specialist about breastfeeding if they need it.
- % of women and men who have positive attitudes about PLHIV
- % of women and men who believe it is it possible in their community for someone to get a confidential test to find out if he/she is infected with HIV

- % of women and men who believe that getting tested for HIV is viewed as a positive and responsible thing to do by members of their community
- % of women and men who reported facing barriers to accessing ITNs

Progress on the aforementioned indicators will be measured by the endline survey

1.1.2. Percent of targeted population who correctly report causes of specific illness (e.g. HIV/AIDS; malaria; diarrhea) [Mandatory Result]

The indicators under 1.1.2, for which baseline was established (Household Survey) for are:
% of men and women who report comprehensive and correct knowledge of the cause of illness or condition

- Malaria
- Malnutrition
- Diarrhea
- HIV/AIDS

Progress on the aforementioned indicators will be measured by the endline survey

1.1.3. Percent of the target population who recall hearing or seeing or reading a specific HC message

The indicators under 1.1.3, for which a baseline survey was established during household survey is:

- % of men and women of target audiences in the general population who report seeing or hearing or reading a malaria.

1.1.4. Number of health communication materials developed, field tested and disseminated

The target for this Fiscal Year 2016 is 4 communication materials, IHPB strategized to hire additional consultant to help in the development of communication materials to accelerate community activities with CHW's. Three sets of communication materials for pregnant women, adolescents and young adults have been developed. They include posters, flipcharts, booklets and leaflets. The number of communication tools developed and field tested has reached 21 but yet to be disseminated.

Sub-CLIN 1.2: Increased accessibility and availability of health products to individuals and households

Planned for April-June 2016	Achievement and results	Comments
Construct supply chain process map and monitor stock-outs	Activity did not receive Contracting Officer's Representative (COR) approval	Concerns that activity might be a duplication since USAID has other mechanisms to support SCM in Burundi
Conduct quarterly SCM supervision visits for Kirundo, Mukenke, and Busoni health districts	Achieved	Supervision visits conducted.
13 three-day SCM training sessions convened for CHWs in Gashoho and Gahombo health districts	In 4 sessions, 159 CHWs from Gashoho have been trained	Training will continue during July – September 2016 quarter

Planned for April-June 2016	Achievement and results	Comments
	January – March 2016	
Provide essential tools and supplies to support CHWs in CCM focus areas		Tools and supplies provided to Gashoho, Gahombo, Musema and Kirundo Health districts
Avail project vehicles (on as need basis) for timely delivery of commodities to health facilities per districts' requests	Continuous	

During the quarter April – June 2016, key supply chain management (SCM) achievements are:

Construct supply chain process map and monitor stock-outs

During quarter April – June 2016, IHPB was preparing for the start of the SCM consultancy, although it was not approved by USAID due to the timing of the work and concerns of duplicated efforts;until the end of September 2016, SCM activities in Burundi supported by MSH's SIAPS and beginning October 2016, by a new Procurement Supply Management (PSM) Project by Chemonics. As such, the project will develop a simplified methodology for identifying SCM bottlenecks at the district, facility, and community levels. To support the achievement of project results in sub-CLIN 1.2, key SCM content will be developed and integrated into the project's facility-level capacity strengthening and improvement efforts.

Conduct quarterly SCM supervision visits for health districts

In collaboration with the health district office, IHPB organized routine supervision visits in Kirundo, Busoni and Vumbi health districts. These supervisions aimed to reduce stock-outs by improving the calculation of Average Monthly consumption of inputs based on their stock cards, improved filling and keeping management tools, filling tools, and best practices in distribution. Note that during Y2, IHPB organized training for district pharmacy managers and for health centers pharmacy staff.

13 Sessions of 2-day training in supply Chain Management for Community health workers in Gahombo health districts:

According to the need for this training and availability of CHWs, four sessions took place during the quarter January to March 2016 in Gashoho health district. There, 159 CHWs (59 female and 100 males) have been trained by 7 trainers trained in ToT training last year. Other sessions organised for Gahombo health district were supposed to be conducted during the quarter of April to June 2016, but due to the limited availability of CHW, the sessions have been postponed for the following quarter, July to September 2016.

Provide Kits to CHWs in the Community Case Management of Malaria (PECADOM) intervention areas:

The project provides and replenishes kits for CHWs to effectively manage malaria at the community level; this supports more efficient diagnosis and treatment, as well as reduces the workload of health facility staff. The table below presents the CHW kits and materials distributed during the quarter across four

health districts (Gahombo, Gashoho, Kirundo, and Musema). For items that have already been distributed and do not require replenishing, additional items were not distributed.

CHW PECADOM Kit Items	Gahombo HD	Gashoho HD	Kirundo HD	Musema[2] HD
Bags	0	0	0	201
Water bottle/5 L	0	0	0	203
Tea spoons	0	0	0	203
Beakers	0	0	0	203
Individual tracking record for the sick child	242	162	257	208
Gloves	726	486	771	624
Security boxes	242	0	0	208
Wooden safe box	0	0	0	208
Padlock	0	0	0	208
Manual timer	0	0	0	208
Solar lamp	0	0	0	208
Bin pedal	0	0	0	208
Transfer book	0	0	0	208
Requisition cards	0	0	0	208
Stock card	0	0	0	208
Taking algorithm managed at home with fever	0	0	0	208
ICCM book	0	0	0	208
Algorithm on use of rapid diagnostic test	0	0	0	208
Soap (30 pc)	242	160	157	208

Avail project vehicles (on as need basis) for timely delivery of commodities to health facilities per districts' requests

The project has previously provided a supply vehicle for the health district Gashoho to address the district's gaps in laboratory capacity and logistics. This quarter, the project facilitated the transport of samples and results for PCR / DBS, CD4 and viral road analysis from Kayanza and Kirundo health provinces to the National Reference Laboratory and ANSS laboratory for analysis to promote timely and accurate HIV diagnostics and in support of improved HIV outcomes in Burundi - IHPB supported 11 trips from the field office to National Public Health Laboratory (INSP) to transport 252 PCR and 435 viral load blood samples and 195 PCR and 183 viral load results back to facilities in IHPB intervention districts.

[2] IHPB started implementing CCM of malaria in Musema health district in January 2016 necessitating supply of kits while for the other districts, it was on as needed basis.

Progress and discussion on SCM indicators

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec 2015	Jan-March 2016	April 2016	May 2016	Total
1.2.1 Percent of supported facilities that experienced a stock-out at any point during the last three months [Mandatory Result]	65%	64.7%	64.3%	43.3%	44%	
1.2.2 Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of any contraceptive methods that the SDP is expected to provide [FP/RH 3.1.7.1-2]	20%	28.2%	4.1%	2%	2.7%	
1.2.3 Percent of health centers that meet defined standards in supply chain management	88%	NA	NA	NA	NA	

% of supported facilities that experience a stock-out at any time during the last three months: Data are collected from that national health information system (GESIS). The Y3 target was achieved for the first, second and third quarters – results showed a positive evolution of the trend.

% of USG-assisted service delivery points (SDPs) that experience a stock out of contraceptive methods that the SDP is expected to provide at any time during the reporting period:

The data are collected from the facility reports for contraceptive products. The data showed that for the first quarter of Y3, we registered a lot of stock out but for the 2nd and first two months of quarter 3 stock out are reducing and the target could be achieved. The main reason for the stock outs were the lack of requisitions by health facilities. Therefore, moving forward, the project will support the facilities to improve their capacity to produce requisitions to districts in support of reducing stockouts.

% of health centers that meet minimum SCM standards.

The data were calculated from PBF reports; however, the project currently does not have PBF data reports because IHPB is not supporting PBF.

Sub-CLIN 1.3: Strengthened support for positive gender norms and behavior and increased access to GBV services

1.3.a: Strengthened support for positive gender norms and behavior

Planned for April-June 2016	Achievement and results	Comments
Conduct training in gender integrated approaches for district hospital health providers	Achieved	45 health providers trained
Train IHPB and CSO partner staff on gender integration		Scheduled for early July with STTA presence.
Develop Gender Strategy	Gender strategy is under development	Strategy will be ready by August 2016
Implement gender integration activities as specified in the Gender Strategy	Ongoing process that may well go through Y4	

Conduct training in gender-integrated approaches for district hospital health providers

The gender-integrated training was conducted in two sessions of two days each (June 15-16, 2016 in Kayanza and June 21-22, 2016 in Muyinga). The training targeted 45 health providers (20 women and 25 men) from the nine partner health district hospitals. Participants were selected from the following services: pediatrics, HIV, maternity, ANC and Family Planning and health information system (SIS). The objectives are to increase understanding of gender norms and inequalities and how they affect health outcomes, and identify opportunities to address gender themes (e.g. male norms, GBV, service equity, power imbalances within the household) across IHPB interventions and technical strategies. During the practical exercises, participants suggested a number of gender integration initiatives into service delivery. The post-test results showed good improvement on knowledge of gender integrated approaches among the health providers.

Train IHPB on gender integration

In the interest of increasing understanding of gender norms and their inequalities, as well as how they affect health outcomes, and in order to identify opportunities to address gender themes (e.g. male norms, GBV, service equity, power imbalances within the household, etc.) across IHPB interventions and technical strategies, the project has developed a staff-wide training. The training will use gender materials developed by USAID. It has been rescheduled for early July when the Project expects STTA provider, Tracy Orr, to travel to Bujumbura from FHI360 HQ.

Develop gender strategy

The gender strategy is under development in collaboration with project and STTA leads across programmatic and technical areas, with input from USAID and other international and local organizations. It is being developed remotely by FHI 360 HQ and will be completed in July 2016 during the IHPB staff training on gender integration, so that staff mayassist to adapt the Gender Strategy to the local context. It is anticipated that the Gender Strategy document will be completed by August 2016.

Implement gender integration activities as specified in the Gender Strategy

This is an on-going activity as the gender strategy is in development. Some gender integration activities, for instance for M&E, have been ongoing.

Progress and discussion on gender indicators

Indicator	Target FY2016	Achieved to date FY 2016			
		Oct-Dec	Jan-Marc	April-June	Total
1.3.1 Number of project interventions that address at least one gender theme (e.g. male norms, gender-based violence, service equity, power imbalances within the household) [Mandatory result].	4	0	0	1	1

Number of project interventions that address at least one gender theme (e.g. male norms, gender-based violence, service equity, power imbalances within the household)

As mentioned above, a raining was organized on gender (gender norms and inequalities, power imbalances within the household) that affect the demand and provision of health services. It targeted health providers from the nine health districts' hospitals. These trainings are prerequisites to implementing the gender integration interventions planned to begin in Year 4 (October 1, 2016 to September 30, 2017).

1.3. b: Expand access to high quality and comprehensive services for gender based violence (GBV) survivors

Planned for April-June 2016	Achievement and results	Comments
Coordinate and provide support for supervision of GBV clinical services	12 facilities supervised	Faith-based organizations are not offering emergency contraception
Organize SGBV job aid validation workshop	Job aid was addressed to national trainers for their inputs	
Disseminate SGBV job aid through a workshop	Planned for after validation	
Train 104 health and non-health providers from the four provinces on clinical management of SGBV	22 trained during in Muyinga during January – March 2016 quarter	Training for 82 planned for July – September quarter

To further expand access to clinical services for GBV survivors, IHPB conducted the following activities during the quarter of April – June 2016:

Coordinate and provide support for supervision of GBV clinical services

IHPB conducted supervisions on GBV-related services in 12 health facilities from Muyinga (four in Giteranyi, three in Gashoho and five in Muyinga). It was noticed that faith-based facilities (Ruzo, Gisanze, Kagari) are not offering emergency contraceptive and only two health centers (Kagari and Ruzo HC) out three health facilities supervised by project staff had ARV for post-exposure prophylaxis (PEP); there were six cases reported GBV cases from four health facilities.

Organize SGBV job aid validation workshop

The National Program of Reproductive health (PNSR) invited IHPB to a ten-day training-of-trainers' session for national GBV trainers. IHPB was represented by two staff out of the twenty people trained as trainers. This was an opportunity for IHPB to present the SGBV algorithm to the team members who gave their inputs. It was observed during the training was that there were many tools to disseminate in health facilities as Burundians Responding Against Violence and Inequality (BRAVI), a USAID funded program in Burundi implemented by Engender Health, also proposed other tools on the same topic. PNSR will coordinate a workshop to select tools to be disseminated in health facilities.

Progress and discussion on GBV indicators

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec 2015	Jan-March 2016	April 2016	May 2016	Total
1.3.2 Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products	1	0	0	0	0	0
1.3.4 Number of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP)	150	38	39	7	9	93 (62%)
1.3.5 Number of facilities that provide PEP to GBV survivors	27	23	23	41	41	41 (152%)
# of persons trained on GBV case management	104	0	22	0	0	22 (21%)

*Percent of supported districts that have at least one comprehensive GBV program and at least one male involvement initiative with referrals to health services and products: T*he target of this year is 1 health district and it is reported annually and it concerns GBV program and male involvement initiative. We targeted Buhiga health district and started the GBV program when we are conducting training for health facilities in Buhiga(each health facility has at least one provider trained on GBV case management) and the next step will be to implement men involvement activities in the district through community mobilization activities in the first time. Note that all trainings on GBV were postponed and started with the end June with a new manual developed by BRAVI.

Number of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP)

By the end of May 2016, a total of 93 survivors received post-GBV care which is 62% of the IHPB Y3 target. Considering the fact that we did not have data for June, it is anticipated that the target will be fully achieved at the end of the year.

Number of facilities that provide post-exposure prophylaxis (PEP) to GBV survivors

By the end May 2016, a total of 41 health facilities are reporting on PEP provision to GBV survivors, which represents 152 % of the Y3 target. This situation could be explained by the fact that the MPHFA reviewed

its policy related to antiretroviral (ARV) treatment and all satellite sites have now autonomy to prescribe ARVs, while previously only hospitals could prescribe them.

Number of persons trained on GBV case management

By the end of May 2016, only 22 persons out of 104 (21%) were trained. All trainings on GBV were postponed by the PNSR until the BRAVI's training module would be available. During the quarter of July to September 2016, IHPB will organize training sessions to achieve the Y3 target.

CLIN 2: Increased Use of Quality Integrated Health and Support Services

Sub-CLIN 2.1: Increased access to health and support services within communities' community strengthening

Planned for April-June 2016	Achievement and results	Comments
Support BDS quarterly visit to CHWs and COSAs in Kayanza and Muyinga	Achieved	42 health centers from Kayanza organized meetings
Support the BPS to organize a semiannual coordination meeting on community health system in Kayanza and Muyinga provinces	First semiannual meeting held in February 2016	Second semiannual meeting planned for September 2016
Conduct five-day training of 20 trainers from Kirundo and Vumbi on community component of National Protocol of Acute Malnutrition Management	Achieved	19 trainers trained
Conduct three-day training for 345 CHWs from Kirundo and Vumbi health districts on Community Management of Acute Malnutrition, including infant young child feeding (IYCF)	Partially achieved; ongoing	201 CHWs from Vumbi trained; Training for Kirundo planned for August 2016
Support the TPS to conduct a quarterly visit to CHWs to coach them on malnutrition screening and management in Kirundo and Vumbi health districts	Not achieved	Postponed for implementation in September 2016
Conduct a 3-day training of 87 members of 29 COSAs from Kirundo and Muyinga provinces on *Curriculum de Renforcement des COSAs* (curriculum for health committee strengthening)	A session for 30 trainees from Kirundo held in January 2016	Session for Muyinga planned for August 2016
Organize supervision visits to 29 COSAs	Partially achieved; ongoing	7 COSAs in Kayanza supervised

Support BDS quarterly visit to CHWs and COSAs in Kayanza province

With the objective to strengthen the link between health centers and communities, the project supported 42 health centers of Kayanza province to organize separate quarterly meetings – attended by health center staff, health promotion technicians (HPT), and the president of the health committee (COSA). The meetings were attended by 873 CHWs (458 female and 415 male). An analysis of CHW monthly reports showed discrepancies or discordance within the reports for the following data: (a) Number of households, (b) number of severe acute malnutrition cases versus the number of referrals for malnutrition in under five children, (c) Sum of number of children screened for malnutrition in each category (red, yellow, or green color on mid upper arm circumference and edema) versus the total

number of children screened. Noted discrepancies were corrected. It was noticed that a large number of households do not have latrines; some health centers have a large number of home births; and some households have no LLINs.

Conduct training of 20 trainers from Kirundo and Vumbi on community component of National Protocol of Acute Malnutrition Management

In partnership with the central MPHFA, IHPB organized a 4-day training of trainers of CHWs on the care of acute malnutrition at community level whereby 19 (5 female and 14 male) were trained as trainers: 13 health center heads, 3 HPTs, and 3 district supervisors. Trainers were Vumbi district medical chief, Kirundo province medical chief, Kirundo province health promotion coordinator, 2 staff from the central MPHFA, and IHPB's child health specialist. Themes covered during training were: definition and concept of nutrition; infection-malnutrition cycle; causes and consequences of malnutrition; and seven key behavioral practices to improve child health including; exclusive breastfeeding, complementary feeding, hand washing, diarrhea management, and health care seeking, and use of the standard CHWs report.

Conduct three-day training for 345 CHWs from Kirundo and Vumbi health districts on Community Management of Acute Malnutrition, including IYCF

In collaboration with Vumbi health district and Kirundo province health office, IHPB organized and conducted 3-day training for 201 CHWs (90 female and 111 male) from Vumbi health district on the management of acute malnutrition at community level, including screening, referral, and nutrition education. Training was conducted by 15 trainers - health promotion technician and HC-based health care providers who had been trained as trainers. Parallel trainings were supervised by the Vumbi district medical chief, Kirundo province medical chief, health promotion technician of the geographical area and one person from the central level of MPHFA.

Organize supervision visits to COSAs

A supervision visit was conducted to seven COSAs in Kayanza province with health management committee (COGES[3]) members trained on the management of health center - Kayanza, Rubura, and Kavoga in Kayanza health district; Gakenke, Ngoro, and Rukago in Gahombo health district; and Matongo in Musema health district. The aim was to assess the added value of the training and reinforce the COSA functionality. The methodology adopted was to:

- gather all COSA members in one room at the health center;
- ask the COGES members the added value of the training they had;
- ask the other COSA members on the COSA's organization, role and responsibility;
- explain the history and the purpose of COSA;
- address COSAs members questions, comments, and complaints; and
- discuss these issues with the health center's head; and
- distribute the *Manuel des procedures en santé communautaire* that describes the attributions of all the community health actors.

[3] COGES is a sub-committee of COSA comprising of three members with a relatively high education level and that works closely with the health center managers in health center management while other COSA's members work mainly to assure to the community access to health services.

By completing this process in the seven COSAs and following up, it was observed that: (a) Collaboration between COGES/COSA members and health centers managers has improved; (b) COGES/COSA members are more involved in financial and personnel management; (c) COSA members participate in health center-based personnel conflict resolution; (d) COSA are now more involved in planning, instead of being merely informed; and (e) COSA has its own work plan different from the one of the health center.

Training CHWs on community component of IMCI in Nyabikere

In partnership with the Nyabikere health district, IHPB organized and conducted (separate parallel sessions) a 5-day training attended by 187 CHWs (75 female and 112 male), on the community component of integrated management of childhood illness (IMCI) and on the standard community reporting tool. The community component IMCI consists of promoting a package of seven key behavioral practices meant to improve child health: early initiation and exclusive breastfeeding; complementary feeding; hand washing; diarrhea management; malaria prevention; danger signs recognition; and health services seeking; and immunization.

The training was organized at commune level (Nyabikere health district comprises four administrative communes). CHWs were divided into 30-trainee classes, each one with three trainers. Trainers were health promotion technicians and health center-based care providers who had been trained as trainers. The health district and the province health offices supervised the activity. Group work and role plays were the methodology used. CHWs received the pictorial booklet on the seven key practices of child health and the standard CHW monthly reporting form.

Sub-CLIN 2.2: Increased percent of facilities that provide quality integrated health and support services

2.2. C: Support integration with a quality improvement (QI) model and prepare districts for scale-up of best practices

Planned for April- June 2016	Achievement and results	Comments
Mentor coaches through coaching visits during supportive supervision	46 quality QIT received coaching visits out of 46 planned.	41 reports available, except 5 from Gahombo health district that are not submitted yet.
Organize one learning sessions per province	Postponed for implementation in quarter of July to September 2016	Conflict of agenda due to mother and child health week and the malaria epidemic control.
Document QI work through technical briefs and case study	First draft available for the four health provinces	Final version at the end of demonstration phase (September 2017)
Train 15 curative care providers in Kayanza Province on integration of FP into MH and HIV services	Training held	

During this quarter, support to quality improvement teams (QIT) was impacted by several conflicting priorities of the MPHFA, such as the mother and child health week and malaria epidemic control efforts. This has prevented the organization of learning sessions and limited the number of coaching visits; however, other activities happened as planned.

Mentor coaches through coaching visits during supportive supervision

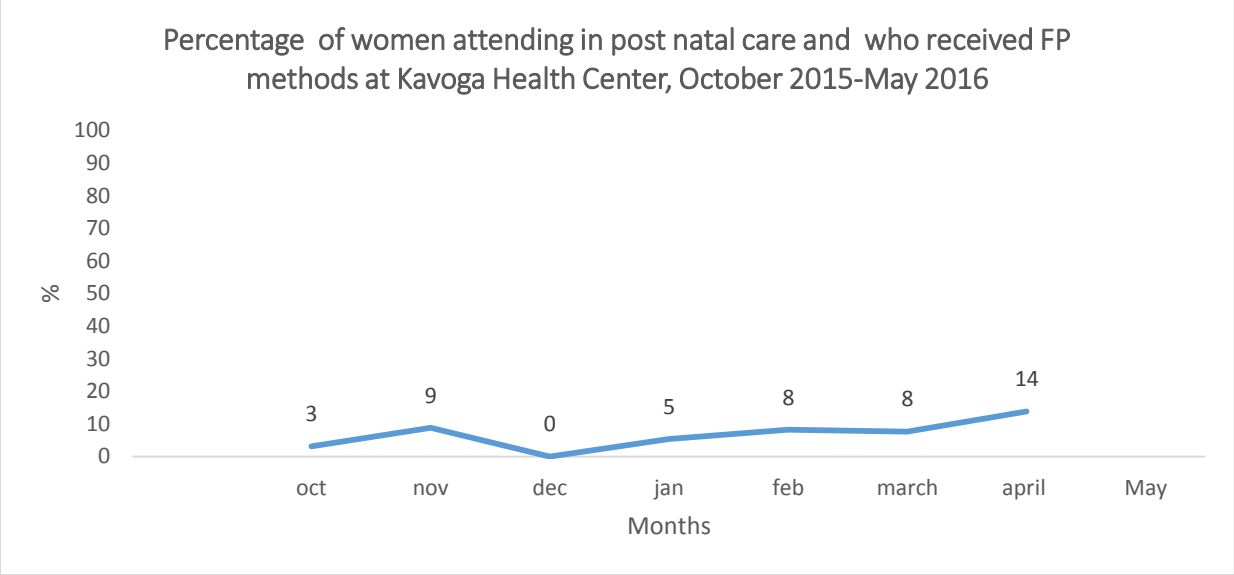
During the quarter of April – June 2016, IHPB, in partnership with respective provinces and health district, conducted five-day mentoring visits with district supervisors trained in coaching QI teams. Five-day mentoring visits were conducted in Kayanza (April 4-8, 2016), Muyinga (May 1-6, 2016) and Kirundo (May 9-12, 2016), respectively. In each province, meetings attended by QIT coaches and IHPB program technical officers (a) allowed the sharing of the updated reporting tool and clarified the objectives of the visits; (b) documented ideas of changes being tested; (c) collected data on indicators related to the change, noting the progress achieved and helping to address potential challenges, checking the quality of data; (d) and providing technical assistance to archive QI materials for integrated services.

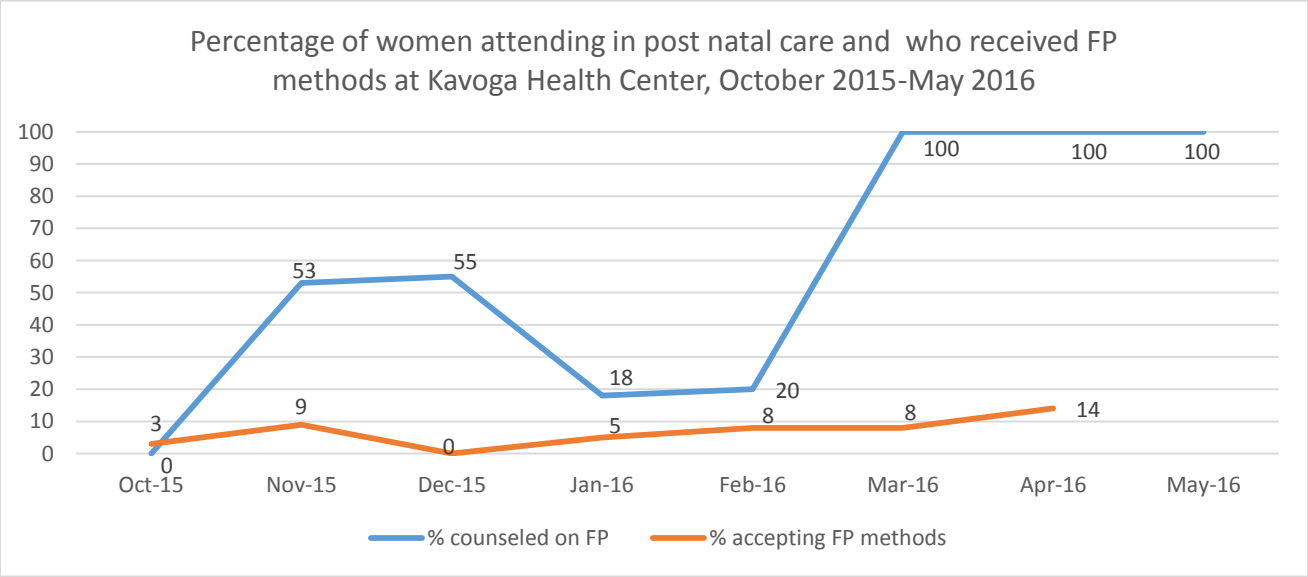
In Kayanza province, where 15 facilities are integrating family planning in maternal health and HIV services through a collaborative approach, it was observed that family planning (FP) counseling is integrated in 13 ANC services (except Musema and Gahombo Hospitals) and nine HIV service delivery pilot sites are providing integrated voluntary family planning. Preliminary results indicate the following:

At the 13 sites, during the period October 2015 to March 2016, a total of 10, 202 women received FP counseling out of 11, 631 (88%) women who attended ANC and 703 out of 5,270 (13%) women who attended postnatal care accepted and received FP methods.

A total 672 out of 3,577 (19%) seropositive women from 9 HIV services delivery points received FP counseling while a total of 572 out of 597 (96%) women were referred by CHW to the HC for methods.

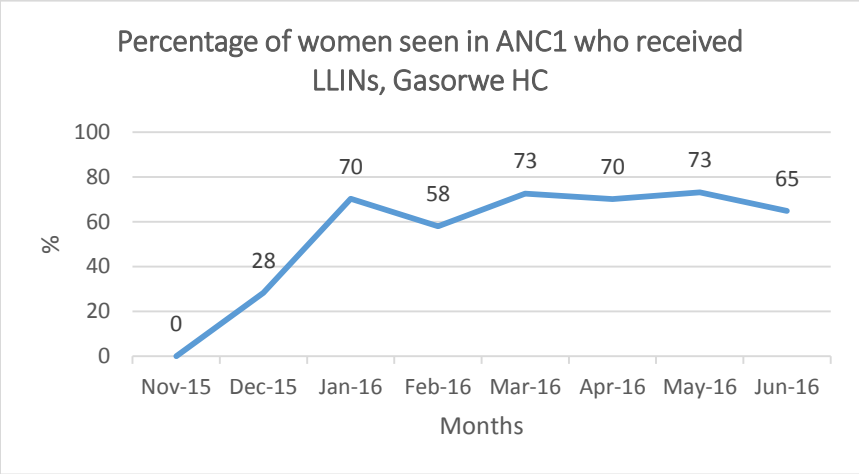
The project documented a QI success story from the Kavoga health center – the HC in-charge stated "Before QI, family planning coverage was low and is now increasing". The main changes that led to improvement are: (a) Assigning permanent qualified personnel in immunization and post-natal care. (b) Identifying and starting with the women who bring children during immunization and who are also in need of postnatal care. (c) Providing FP counseling and accompanying those who accept in postnatal care for methods, so that a woman receives immunization services for a child, postnatal care and FP methods on the same day and in the same structure. Run charts below present graphic presentations of the findings noting that that the percent of women receiving FP counseling in postnatal care. The percentage increased from the time period of October 2015 to May 2016, with the exception of January and February, which was due to providers having to revert their efforts to address the malaria epidemic, as explained by the providers.





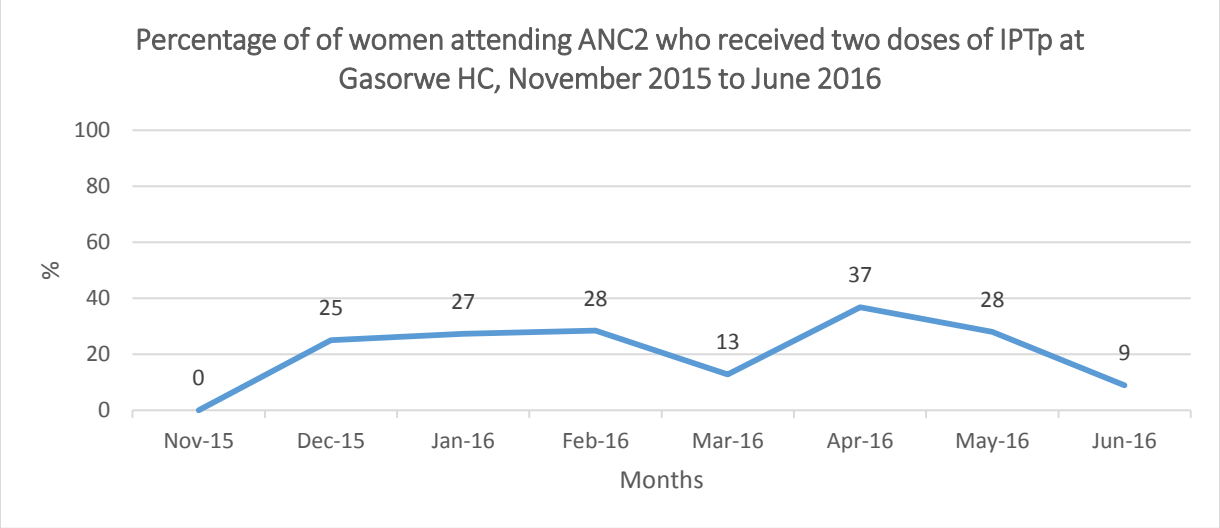
At the end of the five-day coaching visit in Kayanza, recommendations were made to address the key challenges that were observed in some facilities - collaborative documents not well filed; data not collected regularly; lack of trained staff in contraceptive technology; and no calendar of meetings for members of the QIT.

In Muyinga province, mentoring visits were conducted at three facilities integrating malaria prevention into antenatal care services. It was observed that: (a) Group health education conducted on importance of early ANC and IPTp; (b) Commodities (SP, LLINs, Albendazol, Iron and VAT) are available; (c) IPTp is provided and observed in ANC; (d) QIT meets once a week; and (e) LLINs should be managed like a drug. Preliminary data form the three sites show a total of 1,331 out of 1,714 (78%) women attending ANC from December 2015 to May 2016 received LLINs, while 596 out of 1,245 (48%) women attending the second ANC received two doses of IPTp. The run chart below shows some discordance between women receiving ANC1 and LLITNs distributed at Gasorwe HC in Gashoho health district.



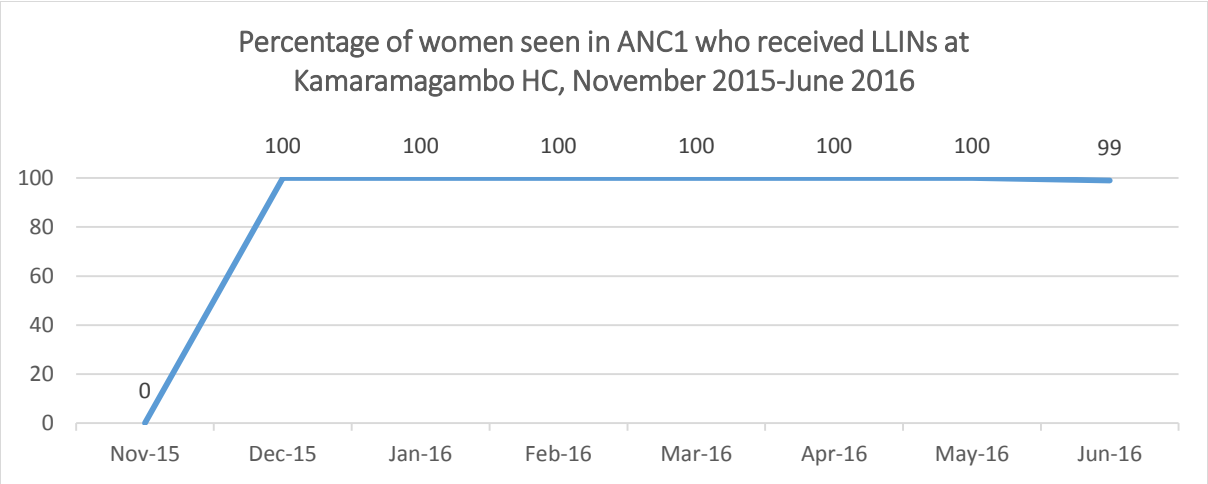
This may be due to some women who leave from the facility without benefit LLITNs due to long waiting time since they are provided at medicines delivery.

The following run chart shows the percent of women who attended the second ANC and who received two doses of SP at the same HC.

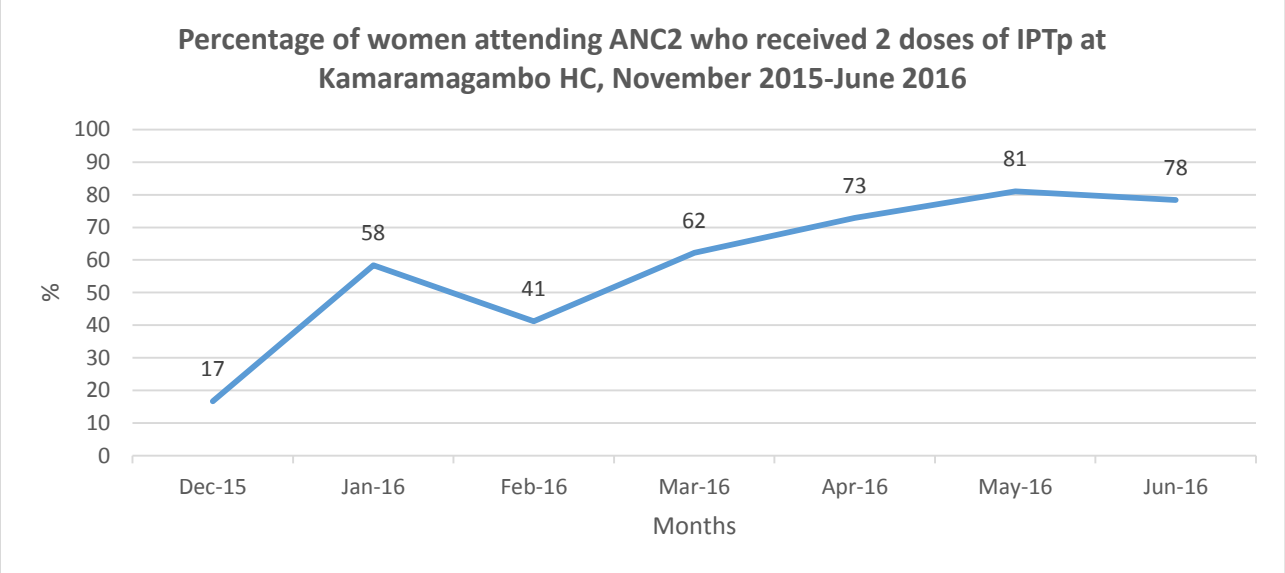


The reason why the number of women attending ANC2 and did not receive two doses is : some of them are not eligible to receive SP, or may have side effects to taking SP. Another reason may be due to incorrect record of SP in ANC registers.

For Kamaramagambo HC, the run chart below shows that all women attended ANC1 received LLINs at Kamaramagambo in Giteranyi health district from December 2015 to June 2016.



The run chart below shows improvements of women receiving two doses of SP in second ANC at Kamaramagambo HC.



Recommendations made at the end of the coaching visit are: (a) Improve the SP recording in the ANC register; (b) Respect the range of 1 month between 2 doses of SP, notify the reason for the non-administration of SP in the register of ANC; (c) Update the process diagram; (d) Update change ideas to be tested; (e) Review the dispensation of medicines delivery to improve patients flow; (f) Record the IPTp dose in the ANC register and in the mother and child notebook – with the corresponding ANC stage; and (g) Record in the observation column register the IPTp side effects in order to identify non eligible woman on SP. A new idea for change to be added into the improvement plan is to order SP based on the Average Monthly Consumption in order to avoid SP stock-out.

In Kirundo province, where 17 facilities that are integrating early ANC, GBV, screening for malnutrition and HIV testing and counseling services in curative care through a collaborative approach, it was observed that: (a) QIT are functional in all four facilities of Vumbi health district, except at Rushubije facility where three QIT members including the chairman and the secretary were assigned to other facilities; (b)

Scheduled meetings are held with good availability of archived reports; (c) Areas of integration are known by all members, (d) the improvement plan is developed and executed monthly at Muramba health center; and (d) Well organized QIT, meetings are planned and displayed, and (e) tasks description in the target services of integration exists and is displayed at Kabanga health center of Busoni health district.

Main challenges encountered in some facilities in the Kirundo province include: (1) Lack of updated process diagram, (2) Meetings are not scheduled (no displayed planning); (3) Lack of job descriptions in the target service integration; and (4) Stock-out of pregnancy tests in curative care. New ideas for change have been identified: to track malnutrition systematically (at waiting room) to all children under 5 years received at health centers; to track malnutrition systematically of all children under 5 years in the community by ASC then refer cases found; and to due to understaffing, hire an additional qualified staff.

Document QI work through technical briefs and case study

A detailed technical report on the QI Collaborative, with a focus on process, has been drafted, following the FHI 360 template for QI stories. This document is being updated gradually as team's progress through the stages of the QI model and results become available.

Sub-CLIN 2.3: Increased capacity of providers and managers to provide quality integrated health services

Planned for April-June 2016	Achievement and results	Comments
Continuously update the IHPB training database	Continuous	The excel data base was continuously updated, with over 5,000 training records for over 3,000 learners entered as of June 2016. Data cleaning and preliminary analysis are underway in July and August 2016.
Continue developing post-training assessment tools	Continuous	With IHPB staff, a draft of an integrated instrument for improvement and capacity strengthening is under development that accounts for post-training assessment
Plan and contribute to measuring health workers' attitudes	To be conducted during the mid-term evaluation	
Plan and coordinate supervision visits supported by IHPB	Achieved	In the post-training follow-up framework, joint supervision visits were conducted in district of Muyinga
Contribute to design and implementation of the supervision system assessment	Ongoing	Integrated instrument for improvement and capacity strengthening will help the project to assess the system. Des variables will be included to allow the supervision system assessment.
Participate in planning district in-service training activities	Planning process start in August	

During this quarter (April-June 2016), the following Sub-CLIN 2.3 activities were conducted:

Continuously update the IHPB training database

The IHPB database of training and trainee records was updated to include all trainings for the quarter, to include a total of six trainings and 384 trainees.

Data on trainings held during the quarter April-June 2016 were entered:

Training of health care providers of Management Bio-Medical Waste

Training of workers on Management Bio-Medical Waste

Training on TB co-infection including TB/HIV

Training of health providers on Active Management of the Third Stage of Labor (AMTSL)

Training counseling of HPT and of Hospital Providers

Training on essential obstetric-neonatal care

In support of the development of an evidence-based Year 4 capacity building plan, an analysis was initiated to show the training's coverage across the IHPB's integrated health topics and by district and facility. Based on preliminary analysis, a total of approximately 3,080 individuals were supported through capacity strengthening by IHPB at a total of 4,893 learner sessions. The training database has been updated to include individual trainee records and IHPB-supported training profiles by district manager, health provider, and CHW can be examined. The updated training database also allows for facility-level review of training coverage. The results from additional analyses in preparation for Y4 workplanning will be used to identify which facilities have staff recently trained in these areas, the gap to cover and the level of integrated health skills existing at the facility level.

The project team is considering how to use of tablets and digital data collection at the training sites by trainers and trainees could improve the efficiency and accuracy of trainee tracking, as well as contribute to better human resources management in general.

Continue developing the post-training assessment

An integrated instrument for improvement and capacity building has been initiated across the project team, including HSS members. The paper version of the first draft of the modules and the instrument has been initially drafted. The ultimate goal is to develop an integrated tool for facility improvement, capacity reinforcement, and supervision support using Open Data Kit (ODK) Collect for deployment on handheld tablet devices. It is anticipated that digital data collection will improve the speed, accuracy and efficiency for evidence-informed facility-level support and to facilitate monitoring and evaluation. The generated information will be used in the form of dashboard that will allow us to plan strengthening activities that respond to project objectives.

Plan and coordinate the supervision visits supported by IHPB

In the post-training follow-up framework, joint supervision visits were conducted in six health facilities in the Muyinga districts in collaboration with the provincial staff of IHPB BDS Muyinga. Six trainees in data analysis were followed up during those supervisions. A previous calendar of post-training follow up is planned for the next quarter (July-September).

Progress and discussion on Sub CLIN 2.3 indicators

Indicators	Target FY2016	Achieved FY 2016			%
		Oct-Dec	**Jan-March**	**April-June**	Total
2.3.1 Percent of trained health providers, managers and CHWs who perform to a defined standard post-training [Mandatory result]	94%	0%	87.5% (n=27)	100% (n=8)	91%
2.3.2 Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training [Mandatory result]	90%	92.4% (n=491)	95.5% (n=414)	95.5% (n=384)	94.3% (n=1,289)
2.3.3 Percent of trained health care staff who report positive attitudes (composite indicator) about work and the workplace	62%	-	-	-	To be conducted during the mid-term evaluation
2.3.4 Percent of health facilities with at least 80% of clients reporting satisfaction with services received [Mandatory result]	100%	-	-	-	PBF source. To be available at the end of August 2016.
2.3.5 Number of health care workers who successfully completed an in-service training program	1,940	491	414	384	1,289 (66.4% of FY16 target)
2.3.6Number of community health/para-social workers who successfully completed a pre-service training program	1,436	0	750	0	750 (52.2% of FY16 target)

Percent of trained health providers, managers and CHWs who perform to a defined standard post-training

With a target of 94%, at the end of June, on average, 91% of those trained performed to a defined standard post-training. With the last quarter we can think that the average performance can increase so as to achieve the FY 2016 target.

During January-March, 15 trainees in Supply Chain Management in Muyinga and 6 trainees in new guidelines of malaria case management were assessed in Kayanza after trainings. Twelve trainees in SCM and four in new guidelines of malaria case management were assessed on their post training performance.

During April-June quarter, eight trainees in Health Information System in Health Facilities in DS Muyinga and seven were assessed on their post training performance. Note that during the October-December quarter, no assessment was conducted.

Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training

Pre and post-test are regularly given and results are collected and the progress by trainee is estimated. We believe that we will maintain up the target which was estimated at 90%.

Respectively 491, 414, and 384 trainees were trained in the 1st, 2nd and 3rd quarters. From the pre and post-tests in the 1st quarter, 92.4% of trainees improved their scores. For the 2nd and 3rd quarters, 95.5% demonstrated improved scores. For the three quarters, 94.3% of trainees improved their scores.

Percent of trained health care staff who report positive attitudes about work and the workplace (composite indicator)

The target for positive health worker attitudes is set to 62%. This indicator is scheduled to be measured at the upcoming mid-term evaluation through Facility Qualitative Assessment (FQA) - Health Provider Interviews.

Percent of health facilities with at least 80% of clients reporting satisfaction with services received

This is a PBF indicator with a target of 100%. Data for 2016 will be available at the end of August.

Number of health care workers who successfully completed an in-service training program

As planned, 1,940 managers and health workers will be trained this year. Through June 2016 (the third quarter) 1,289 learners were trained, which represents two-thirds (66.4%) of the annual target for number of trainees receiving trainings supported by the IHPB project in FY16.

Number of community health/para-social workers who successfully completed a pre-service training program

A total of 1,436 Community Health Workers are targeted to be trained by the end of FY 16; currently 750, or 52.2% of the annual target, have already been trained.

CLIN 3: Strengthened Health Systems and Capacity

Sub-CLIN 3.1: Strengthened decentralized health care and systems in targeted geographic areas

3.1. a.: Work with provincial and district health bureaus to progressively strengthen district-level capacity and performance in managing the decentralized health system

Planned for April– June 2016	Achievement and results	Comments
Identify, reproduce and distribute all current national health policies, protocols, and guidelines needed by FOSAs	Continuous	Current national guidelines and other related documents are distributed during training or supervision.
Improve quarterly coordination meetings	One coordination workshop supported per district, except the Muyinga health district	Few joint supervisions between IHPB and BDS are done because of the health districts' conflicting agenda
Assess and strengthen supervision system	IHPB supported and conducted 36 supervision visits	There are no joint planning supervisions visits between BDS and IHPB provincial and districts don't provide feedback to facilities. IHPB organized a session training to all district managers in integrated supervision system
Support districts' annual work planning process	Activity will begin in September	To reinforce the capacity of health districts team on planning, IHPB organized a session five-day training to all district managers in planning process from 11th to 15th July 2016.

Identify, reproduce and distribute all current national health policies, protocols, and guidelines needed by FOSAs

During this quarter, there were no new national health policies, protocols, or guidelines produced; however, IHPB continues to distribute manuals and tools used for delivering integrated and quality health services as following:

- 203 guidelines for CHWs (manuels de l'Agent de Santé Communautaire pour les 7 pratiques clés) in Nyabikere health district.
- "le circuit de dispensation du medicament" in the 45 health centers and 3 district hospitals of Kayanza health province.
- New guidelines for HIV (dossiers du patient VIH enfant et adulte) in 16 health centers of Kayanza health district, 6 health facilities of Gahombo health district and 5 health facilities of Musema health district.

These documents are regularly distributed during training or supervision. IHPB has a list of relevant guidelines, policies and protocols (SARA: all current national policies, protocols, and/or guidelines in the areas of HIV, MNCH, FP/RH, and Malaria) and has shared it with health district managers. Every month, STA/HSS collaborate with the specialists in the four project domains to analyze if the database is up-to-

date (if there are new documents or not). New documents are obtained in different national health programs or provided the MOH (national level). The information is shared during meetings/workshops.
Documents are not available in the facilities for many raisons:

The documents are produced by national programs and health districts must come to Bujumbura to distribute them to facilities. Or some health districts don't have vehicle to do it,
Some donors distribute the documents to health district but the documents are not distributed to facilities

There is not a specific system to assess the availability of those documents and the facility responsibles are not conscientious that all these documents are very important for their activities.
Documents distributed during training sessions are considered than an individual propriety and when the provider moves, he leaves with the documents.

To address the issue of continuous availability of these documents without dependency from IHPB, health districts have the database of all documents and are advised to help facilities to receive all new documents and to find a place at health facilities including hospitals, where they can be stocked (a stock of the documents: *bibliothèque bleu*) where every provider can use them if necessary.

Improve quarterly coordination meetings

IHBP continued to provide financial assistance through sub-grants to districts to organize their coordination meetings. Eleven districts held their coordination meetings as planned. The 12th health district is Muyinga and has been advised to collaborate with IHPB bureaus to prepare the quarterly coordination meeting.

STA/HSS and Field Officer managers participated in the quarterly meetings and utilized a variety of approaches, techniques and strategies to strengthen the capacities of health district team, including informal, formal and individual activities to increase their capacity to organize this kind of meeting.

The participants found now that these meetings are key opportunities to discuss health, resources and management needs and priorities and look for solutions. During meetings, IHPB presented to the participants the activities that can be supported, how to make demand sensitized district and BPS to ensure cash requests for the activity are timely introduced and jointly prepare agenda. IHPB works side-by-side with health district and province teams to prepare the meeting, to send invitations and to conduct the activities during meeting. Heath districts and province are satisfied of the support, and the results that well-organized and coordinated meetings bring.

For example, at Kayanza health province, during the coordination meeting in April, participants evaluated the work plan of each district and decisions were made to organize joint supervision, joint planning, and to accelerate HIV activities. After two months, 3 new sites of ARV were opened, and additional joint supervisions were organized.

During a coordination meeting in April in Kirundo health province, the participants discussed major causes of district-level stockouts, as well as the problem of transportation of certain commodities to

avoid stock-outs for the four health district pharmacies of Kirundo province. As a result of the meeting, they recommended to reinforce the capacity of managers in quantification of stock supply. In addition, to fill the gap, IHPB provided a vehicle to the provincial team for transportation to restock supplies. As a result of the IHPB-supported coordination meetings, health system issues were addressed so that the availability of drugs and supplies, and thus the quality of services provided, improved.

Participants also discussed on a strategy of sensitization health care providers to integrate HIV counseling and testing (HTC) into their services: Inpatient wards (Internal Medicine, pediatric, Gynecology and obstetrical, surgery) and outpatient units (adult and infant outpatient, emergency). They appreciated the support that IHPB provides to the health districts (TPS) to conduct a quarterly visit to CHWs to coach them on malnutrition screening and management in Kirundo and Vumbi health districts. The support has been appreciated.

In Kayanza health province, the participants appreciated the support to CHWs that IHPB provides to facilitate community-level implementation of the Community Mobilization Guide. Participants also discussed on a variety of challenges in attempting to avoid stock outs at community level that CHWs faced. They also discussed on how to identify zones with high risk of HIV infection targeting Key populations (FSW, MSM & LGBTI) and other groups with higher risk of HIV transmission (single mothers, separated couples, men and women with sexual multiple partners, waiters/waitresses). Discussions included awareness on the modes of HIV transmission, HIV prevention methods, factors favoring the spread of HIV, HIV testing and counseling, health care for PLWHA as well as testimonies from those living positively with HIV. Participants proposed that HIV testing to be organized on site for who want to know his/her serologic status.

Assess and strengthen the supervision system

IHPB continued to support district health management teams to conduct their supervision visits, both logistically and financially through sub-grants. IHPB and Health districts conducted joint supervision visits of FOSAs where IHPB staff accompany the district supervisors, monitor their supervision skills, and provide feedback on their performance.

In order to strengthen the supervision system and make it less dependent on a project, IHPB is developing a supervision assessment tool to support all aspects of a supervision system, from planning to evaluation, including steps involved in supervision visit, from preparation to reporting. This tool will be finalized and deployed in Y4. The new, more integrated processes introduced by the tool, and the manner in which data is generated and used will better guide provinces and districts to provide effective supervision.

Support districts' annual work planning process

This activity is planned to start in September 2016. To reinforce the capacity of health districts team on planning, IHPB organized a session training to all district managers in planning process. 24 participants of Karusi province, 28 of Kayanza, 34 of Kirundo and 29 of Muyinga attended the session.

Discussion and analysis of HSS results

		Achieved to date FY 2016

Indicator	Target FY2016	Oct-Dec 2015	Jan-March 2016	April 2016	May 2016	Total
3.1.1. Percent of supported facilities that have available all current national health policies, protocols, and guidelines [Mandatory Result]	FP/RH: 30% (52/173) ANC: 50% (87/173) MH: 50% (87/173) CH : 30% (52/173) HIV/AIDS : 50% (48/96) Malaria: 89% (154/173) GBV: 30% (52/173)	-	-	-	-	
3.1.2 Percent of supported facilities that have 70% of the required equipment to provide core/expanded packages of quality integrated health services [Mandatory Result]	MNH: 98% for district hospital 96% for health centers; CH: 95% for district hospital and 91% for HCs; laboratory: 49.6% for district hospitals and 68.2 for health centers					
3.1.3 Percent of supported facilities that have the capacity to perform clinical laboratory tests [PEPFAR LAB_CAP]	80 % (4 out of five district hospitals where HIV/AIDS activities are underway	80%	80%	80%	80%	
3.1.4 Number of PBF indicators supported by the project [Mandatory Result]	IHPB ceased supporting PBF at start of in Y3.					
3.1.5 Percent of supported districts and provinces that conduct planning and resource coordination meetings on a continual basis [Mandatory Result]	100 % (all 12 districts in IHPB provinces)	100%	NA	NA	NA	

Percent of supported facilities that have available all current national health policies, protocols, and guidelines [Mandatory Result]

The indicator represents the percent of supported hospitals and health centers that have available all current national policies, protocols, and/or guidelines in the areas of HIV, MNCH, FP/RH, and Malaria. This indicator is reported annually and will be at the end of the fiscal year (September, 30th 2016). As you know, these documents are regularly distributed during training or supervision and it is anticipated that the target will be reached.

Percent of supported districts and provinces that resource coordination meetings on a continual basis [Mandatory Result]

The indicator represents the percent of supported districts and provinces that conduct resource coordination meetings on a quarterly basis. Resource coordination meetings are held in the remaining quarters (three times per year).

The annual FY16 target was estimated to 100% (36/36) and at the end of June, the achievement of this indicator is 96% (35/36). With the last quarter we can think that the 12th health district (Muyinga) will organize the coordination meeting as others and it is anticipated that the target will be reached.

Percent of supported districts and provinces that conduct planning on a continual basis [Mandatory Result]
The indicator presents the percent of supported districts and provinces that conduct planning. Planning meetings are conducted annually and IHPB planned to support these meetings for the 12 health districts and the 4 health provinces. IHPB will reach this target.

Sub-CLIN 3.2: Strengthen M&E and data management systems at the facility and community levels

Planned for April-June 2016	Achievement and results	Comments
Train 345 CHWs on standardized reporting tools to initiate and improve reporting of community-driven data	994 CHWs trained on the use of standard report form "GASC"	200 trained in Vumbi district 794 trained in Gashoho district
Conduct Routine facility data quality assurance (DQA)	29 health facilities visited	
Organize a five-day session to train BPS and BDS staff in data demand and use	Included in a comprehensive training on Health District Management planned for July 2016	Training was not specifically conducted on the topic but data demand and use is regularly discussed during quarterly data analysis workshops. In addition, in partnership with the Department of Planning (MPHFA), IHPB planned to train BPS and BDS staff in district management including modules on M&E and HIS, them that include data demand and use
Strengthen capacity of district teams and facility managers on data use through quarterly district data analysis workshops	7 data analysis workshops organized	Due to agenda conflict, other 5 districts were not able to organize the activity.
Develop and disseminate data visualization dashboards for use at the facility level	Ongoing	

Train 345 CHWs on standardized reporting tools to initiate and improve reporting of community-driven data
As it has not been possible to train Community Health Workers (CHW) on the use of standard reporting tool during quarter two (January-March 2016) due to conflicts of agenda, IHPB successfully conducted that activity during the quarter under review and results exceeded expectations. Initially, a training of 19 trainers (14 male and 5 female) was conducted in Kirundo province. Thereafter, for 345 CHW targeted, 994 CHWs (577 males and 417 males) were trained on the use of standard reporting tool (GASC) including 200 from Vumbi district and 794 from Gashoho district. The topic was either included as a module in another training (Vumbi) or conducted as a one-day training, taking opportunity of planned CHW monthly

meetings (Gashoho). In addition, 590 other CHWs of Kayanza (329) and Gahombo (261) HDs received a refresher training on the use of the Groupement d'Agents de Santé communautaire (GASC) tool.

In addition, in order to strengthen the Community health workers (CHW) reporting skills on community case management (CCM) of malaria, working sessions were conducted in 15 health centers of Musema Health District, Kayanza province.

Conduct data quality assessments (DQAs)

IHPB conducted routine data quality assessments (DQAs) in 29 health facilities (7 Kayanza, 4 in Karusi, 6 in Muyinga, and 12 in Kirundo) on various supported areas. The main areas targeted include the improvement of ART sites' autonomy about PLHIV monitoring and ART services reporting, IPTp, and Active Management of the Third Stage of Labor (AMTSL), and infant immunization (DPT3)

The DQA exercises discovered a number of common data quality limits such as discrepancies in numbers reported and verified; lack of source documents for some project-specific data not yet included in standard tools; and incompleteness of some registers. Following those limits, some actions were taken: (a) filling all relevant register columns, (b) improving data cross-checking across tools used for services and management of commodities; (c) aggregating data per page in order to reduce aggregation errors at the end of the month; (d) improving notification of ITNs in the ANC register; (e) regular notification of uterotonics administered to women after delivery in maternity registers; (f) peer review of data before transmission to the district level; (g) correcting noticed data discrepancies.

Strengthen capacity of district teams and facility managers on data use through quarterly district data analysis workshops

In order to strengthen health district coordination and skills on data quality and data use, IHPB supported seven (7) quarterly data quality review meetings in Kayanza, Musema, Buhiga, Nyabikere, Giteranyi, Muyinga and Krundo health districts. IHPB supported also Karusi Provincial data quality review workshop. Attendees of such workshops are the district core teams, all health promotion technicians and a representative of each health facility. Topics discussed included data related to child health, immunization, antenatal care, AMTSL, IPTp, malaria, and HIV services. IHPB staff took the opportunity during those workshops to share facility experiences, discuss observations made during routine DQA exercises and suggestions for improvements, not only for data quality but also for service uptake.

The triangulation of ANC and assisted delivery data in GESIS and data reported on AMTSL and IPTp services showed that there are a lot of discrepancies across facilities. That situation may be explained by the absence of standard tools for AMTSL and IPTp. Recommendation formulated include: data cross-check before report writing and transmission, creation of an additional column in maternity and ANC registers for the notification of those services. In some health districts (Kayanza and Musema), data analysis revealed that uptake of FP methods is decreasing starting 2015. Reasons raised include political rumors throughout the electoral process of 2015 and religious beliefs. Participants recommended strengthening community FP awareness with the involvement of CHW networks and local administration.

Data review revealed also a low uptake of early ANC, and consistent higher numbers of BCG beneficiaries than those of assisted deliveries bringing to mind persistence of high rates of home deliveries. For

example, 56% (9/16) health centers of Musema HD had an early ANC rate lower than 50%. Health promotion technicians were advised to work much more closely with CHW to promote the awareness of the advantages of assisted delivery and dangers of home deliveries. In fact, health facilities with good achievements testified that their success was due to increasing 35/36 (96%) the commitment of CHWs. On the other side, health providers were advised to improve quality of maternity services.

Another issue discussed within the data analysis workshops is the analysis and use of community-driven data. In fact, community health workers are regularly reporting to health facilities but their data are never included in the workshop presentations and discussions. An agreement was reached for the inclusion of community data in future workshops.

Regarding HIV/AIDS services, discrepancies between the number of HIV-positive pregnant women receiving delivery services and the number of exposed infants enrolled on ARV prophylaxis were noted. Participants agreed on the need to ensure care for exposed infants through follow-up and to engender an AIDS-free generation.

Develop and disseminate data visualization dashboards for use at the facility level

After a situational analysis about availability and use of data dashboards conducted in March 2016, IHPB M&E technical officers updated health facilities on the importance of using data dashboards to review results and consider informed actions according to their needs. However, one of the findings of field visits during the period under review is that some health facilities (four visited in Karusi) do not update them regularly and a number of health providers were not able to fill them. According to capacity needs, project staff worked to build their capacity and interest on using dashboards to track facility-level progress.

Progress and discussion on M&E indicators

Indicator	Target FY 2016	Oct- Dec 2015	Jan – March 2016	Apr – June	EP Target
3.2.1 Percent of facilities that maintain timely reporting [Mandatory result]	97.8%	100%	100%	100%	+5%
3.2.2 Percent of districts and facilities that demonstrably use facility- and community-level data for timely decision making [Mandatory result]	Facility: 90% District: 80%				+10%

There are two IHPB contractual indicators related to M&E area:

1) Percent of facilities that maintain timely reporting: this indicator already had a good baseline. Thanks to the Performance-based financing mechanism, achievement is consistently good and IHPB works to keep the good level reached.
2) Percent of provinces, districts and facilities that demonstrably use facility- and community-level data for timely decision making: this indicator is informed through assessment. So far, only the baseline set

at end 2014 is available, although it is supposed to be assessed on an annual basis. IHPB plans to conduct a light (smaller) assessment this year in order inform progress made since.

Sub-CLIN 3.3: Increased civil society capacity to support positive behaviors and quality integrated services

Planned for April – June 2016	Achievement and Results	Comments
Provide support to CSOs for improving management systems, including financial management and human resources management, through at least quarterly visits	Achieved	IHPB staff coached ANSS and RBP+ administrative and financial staff on a series of ongoing topics
Conduct quarterly joint supportive supervisions focused on technical activities	Achieved	IHPB staff in collaboration with the antenna coordinators, conducted supportive supervision to ANSS and RBP+ field staff in Kirundo
Ensure CSO VAT requirements	Achieved	RBP+ documented and will claim VAT reimbursement in July ANSS did not get bills with VAT this period

Provide support to CSOs in improving management systems, financial management, and human resources management through at least quarterly visits:

For improving management systems, with a special emphasis on financial management and human resources management, IHPB staff from the finance team conducted supportive supervision addressed to the staff from ANSS and RBP+ in provincial field offices. This supervision aimed to assess whether the recommendations from previous evaluations have been implemented. In RBP+ and ANSS, all the recommendations issued from the last supervision were implemented: procedures documents were in place, monthly financial reports were completed and classified by budget item, fringe benefits for pension or professional risks and taxes for government were declared and paid on time, USAID Logos were posted on all equipment according the branding and marking policy and the inventory was updated. The recommendations from the previous visit in terms of updating personnel contracts, authorization trips were also followed. For the refund of VAT, RBP+ documented and will claim VAT reimbursement in July. In ANSS, there was no case of VAT payment during this year.

Conduct quarterly joint supportive supervisions focused on technical activities:

In 2015, USAID team with IHPB staff and health district staff conducted a supervision focused on HIV activities using the SIMS tool for ANSS Kirundo and RBP+ Kirundo. Recommendations for improvement were formulated. IHPB staff supported the 2 CSOs to develop an improvement plan. Quarterly supervision visits have been conducted in order to monitor the implementation of the improvement plan. During the supervision of ANSS Kirundo conducted in December 2015, it was noted that there have been failures by the management to follow up on cases of loss-to-follow-up. The issued recommendations have been implemented: procedures to search for lost to follow up developed, use of SIDA INFO program to identify those who need follow up, cards made for follow up developed, log book for follow up in place, elections at colline and communal level of leaders in charge of identifying the lost to follow up, home visits carried out by ANSS volunteers. The filing system was improved and codified as follows: 00: Patients on ARVs; 05: Patients on Cotrimoxazole who are not on ARVs; 08: seronegative patients (children under two years); 09: patients with unknown status. Now the Early Infant Diagnosis by PCR analysis is done by the routing of samples to INSP.
In RBP+, all recommendations have been implemented but it has no specific program for adolescents. Thanks to the data base put in place by IHPB, all the OVC issues related to education, nutrition, health support, court cases are registered and an automatic report is produced.

Ensure CSO VAT requirements:
Organizations implementing development projects funded by the US government are exempted from certain taxes (including the Value Added Tax) imposed by the Government of Burundi and exemptions cover both the principal recipients and sub-recipients. The claim of the VAT refund for any invoice of amount equal or greater than $500 is mandatory. RBP+ documented and will claim VAT reimbursement in July 2016. ANSS did not get bills with VAT during this period.

In addition to the activities planned this quarter in the work plan, IHPB conducted following activities:

Sign new amendment with ANSS
During this period, in order to accelerate IHPB achievements in HIV activities, the project initiated procedures with both USAID and FHI 360 (HQ) in order to maintain ANNS as a partner for the remaining life of project by carrying out a modification aimed at (1) increasing the SOW, (2) extending the LOP, and (3) increasing estimated and obligated budgets. COR provided concurrence and FHI 360 made the necessary review. Finally, the amendment was signed by both FHI 360 and ANSS. The new SOW focuses on HIV services integration and key populations (MSM, FSW) in areas with high risk of HIV infection in Kirundo province. It starts on July 1st, 2016 and ends September 30, 2018.

Modifications of SWAA Burundi Sub-agreement
SWAA Burundi will work in HIV service integration and will add activities focused on key populations (MSM, FSW) in areas with high risk of HIV infection in Kayanza province. Currently, IHPB and SWAA Burundi staffs are jointly preparing the project description and the budget in order to complete the modification.

Modifications of RBP+ Sub-agreement:

RBP+ will work at community level to increase the HIV screening and treatment and to address the challenges of achieving the objectives of the fast track goal in Kirundo and Kayanza provinces. The draft project description is ready to be shared with RBP+.

Training on National guidelines for malaria treatment:

Training on management of uncomplicated and severe malaria in Burundi's health facilities for 4 ANSS providers involved in medical care—3 nurses and 1 laboratory assistant—was conducted. The results achieved included an improvement of knowledge on the clinical diagnosis of malaria, the treatment of severe and uncomplicated cases of malaria, handling and interpretation of RDT and ways of preventing malaria.

Training on Sexual Transmitted infections:

The objective of the training was to enhance the skills of the ANSS health providers to enable them to properly fulfill their role in syndromic management of sexually transmitted infections. The training was organized for the four antenna nurses. At the end of the training, participants have improved knowledge and skills in the syndromic management of sexual transmitted infections, the use of algorithms, education and counseling the patient, the partner care and improving of data collection.

Progress and discussion on CSO indicators

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec	Jan-March	April	May	Total
3.3.1 Number of supported CSOs with demonstrated improvements in key technical and organizational capacity areas (e.g. quality of services, service coverage, and related areas) [Mandatory result]	4	3	2	2	2	**3**
3.3.2 Number of CSOs that transition (graduate) and qualify to receive direct USAID funding	3	0	3	3	3	**3**
3.3.3 Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS [PEPFAR OVC_SERV_DSD]	2,448					
3.3.5 Number of organizational capacity assessments completed with supported CSOs	4	3	3	3	3	**3**

Number of supported CSOs with demonstrated improvements in key technical and organizational capacity areas:

The three CSOs (ANSS, SWAA Burundi and RBP+) supported by IHPB, were assessed with Institutional Development (IDF) tool and Non-US Organization Pre Award Survey (NUPAS) tool. The CSOs assessed demonstrated improvement in both technical and organizational domains.

Number of CSOs that transition (graduate) and qualify to receive direct USAID funding:

IHPB submitted in March 2016 the Local Partner Transition report in which it proposed that 3 CSOs have graduated to direct USAID funding.

***Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS*:** Through RBP+ grant, during the months of April and May 2016, IHPB served a total of 1,117 OVC (469 male and 648 female). Assistance includes school support, healthcare, juridical assistance, psychological assistance, hygienic kits and nutritional counseling. For details, refer to HIV/AIDS Strategy.

Number of CSOs that improved their organizational capacity with USG assistance (using IDF tool):
Using the IDF tool, the 3 CSOs were assessed at the beginning of project implementation in July and August 2014 to determine the performance baseline and in November 2015 to measure the progress made.

Priority Health Domain Strategies

Maternal and Newborn Health Strategy

Planned for April-June 2016	Achievement and results	Comments
Conduct formative supervision for BEmONC in Karusi, Kirundo and Muyinga	Due to non-availability of National trainers, BEmONC did not take place	IHPB will train a pool of trainers from the four IHPB provinces
Support Maternal death audits in 9 hospitals	3 sessions conducted (Gahombo, Gashoho and Giteranyi)	
Train 45 health providers and health district supervisors on EONC	15 trained	Y3 target to train 45 achieved

Conduct formative joint supervision for MNH services:
During the quarter, due to non-availability of national trainers, joint supervisions for support to providing high-quality BEmONC did not take place. To remedy the situation, IHPB is planning to train trainers and supervisors from across the four provinces. However, joint field supervisions of MCH activities were conducted for 25 health centers in Kayanza (13), Kirundo (6) and Muyinga (6) by field-based IHPB staff. Findings include: (a) Oxytocin is not administered systematically after childbirth across all facilities and deliveries. The action will be to conduct small training on the use of uterotonics to prevent postpartum hemorrhage and (b) Following home delivery, mothers seek post-natal care after their health is already in danger. This mandates the need to implement a community strategy to sensitize pregnant women on importance of delivery by skilled birth attendant.

Organized three three-day training sessions on active management of the third stage of labor (AMTSL):
In collaboration with respective health district bureaus, IHPB organized three three-day training sessions for 61 (36 males and 25 female) health workers from Gahombo (39) and Musema (22) on active

management of the third stage of labor (AMTSL). These trainings were conducted following supervisions conducted last quarter from which we found that there was a need of strengthening capacity of health providers on MCH related topics including Active Monitoring of the Third Stage of Labor (AMTSL).

Organized a ten-days training of trainer's session on Essential obstetric and neonatal care (EONC) for 30 health providers:

In collaboration with PNSR, IHPB organized a ten-day training of trainer's session on *EONC* for 15 people (14 males and 1 female) from Karusi (6) and Muyinga (9)-. Trainings were conducted in Gitega. The aim of the trainings was to strengthen health district staff capacity as trainers and supervisors of EONC activities. The session was organized in three parts; (1) participants completed a series of theoretical topics (in class) related to antenatal care, safe delivery and postnatal care for two days. (2) Four days of practical sessions took place, using a standardized checklist to promote competencies in offering high-quality perinatal services. Three stations were established where participant knowledge and competencies were assessed three times: at the beginning by a pre-test, during the training using a mid-evaluation test and at the end of the session by a post test. The first station assessed skills providing antenatal services, including PMTCT. The second station assessed safe delivery, including the active management of the third stage of labor (AMTSL), administering uterotonics, and newborn resuscitation. The third station was to assess participant competencies to provide post-natal services with a focus on episiotomy and mother resuscitation (3) After the station-based knowledge and competency, participants returned to their facilities to apply their skills for 2 days. In addition, they practiced training other facility staff on the aforementioned topics for 2 days. The average increase in individual participant knowledge from 57.14% up to 86.61%; the average score in demonstrated competencies to offer EONC services increased from under 30% to over 70% in all perinatal care stations. In terms of participants' measured competency to train others, the average score was 87.2% for theory training and 88.2 for practical training competencies using standard National Program of Reproductive Health (PNSR) tool which is part of the training.

Participated in regional workshops on maternal death surveillance organized by PNSR[4]:

The PNSR invited IHPB to facilitate and contribute to workshops on maternal death surveillance. The workshops were organized by region - IHPB participated in the one that was held in Muyinga and Ngozi, where Karusi falls). All the provinces expressed the need for improved maternal death surveillance and the necessity of conducting audit for any maternal death within 30 days of the occurrence. IHPB currently supports maternal death audits in the 4 provinces.

Progress and discussion on maternal and neonatal health indicators

Indicator	**Target FY2016**	**Achieved to date FY**				
		Oct-Dec	**Jan-Marc**	**April**	**May**	**Total**
2.0.5 Number/percent of women giving birth who received uterotonic in the third stage of labor through USG-supported programs	18% 0f estimated deliveries of 104,685 i.e. 18,843	8,773	10,690	3,632	3,921	27,016 (143%)

[4] These workshops were not organized by IHPB but we were invited for technical support by the MPHFA(PNSR)

Number of people trained in maternal /newborn through Burundi MCH supported programs	75		60	15	61	136 (181%)
Number of USG-supported facilities that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC	50	38	38	38	38	38 (76%)

Number of women giving birth who received uterotonic in the third stage of labor through USG-supported programs

The above table shows that during the 3 quarter of Y3, a total of 27,016 women (143% of the target) received uterotonic during the third phase of labor to prevent postpartum hemorrhage in the targeted areas. But if we consider the total number of delivery in health facilities, we are at 26% (27,016/104,685) of woman giving birth in health facilities who received uterotonic.

Number of people trained in maternal /newborn through Burundi MCH supported programs.

The target of 75 set for the Y3 was established according to the trainings we planned and we overreached the target and trained 136 persons (181%). But while conducting supervision and analyzing data related to active management of the third stage of labor (AMTSL), only 26% of women giving birth received uterotonic and we still have health facilities which are not giving uterotonic, we noticed that there we necessity to conduct small easy trainings on AMTSL to prevent post-partum hemorrhage which is the first cause of maternal mortality in Burundi.

Number of USG-supported facilities that provide appropriate life-saving maternity care (This will be defined as seven signal functions for BEmONC and nine signal functions for CEmONC.

The SARA identified 38 health facilities providing *life-saving maternity care as defined by the seven signal functions for BEmONC and the nine functions for CEmONC*. IHPB conducted training on BEmONC for a total of 86 health providers from 43 health facilities in Karusi, Kirundo, and Muyinga. The mid-term survey will inform better how far we are on this indicator.

Reproductive Health Strategy

Planned for April-June 2016	Achievement and results	Comments
Conduct monthly follow-up on FP activities at health facility level	Ongoing	4 supervisions sessions held
Organize sensitization meeting to the leaders on reproductive health	On going	Through CBDC's sensitization sessions and mobile clinic

Conduct monthly follow-up on reproductive activities health facility level:

In partnership with health district offices, IHPB conducted integrated supervision visits, during which FP-related services were addressed. A total of 12 health centers were supervised in Kayanza (6), Kirundo (3) and Muyinga (3). In Nyungu, health staff, in partnership with local administrative and school authorities,

organized a session on the following topics: risk behaviors of early and unwanted pregnancy; factors predisposing to unwanted pregnancies; and consequences of pregnancy and abortion among young girls. The session was attended by 35 young people (15 boys and 20 girls) and 18 adults (10 men and 8 women). In Kirundo, a low adherence to contraceptive methods was noted and attribute to rumors. It was then recommended to specify the cause of withdrawal of method within the health facility records and redouble efforts to raise awareness of the population with collaboration with the CHWs and the local administrative authorities in order to address these rumors.

Organized a monthly meeting of community based distributors of contraceptives:

IHPB organized a monthly meeting of community-based distributors of contraceptives (CBDCs) attended by 137 CBDCs (78 males and 59 female) from three health centers of Muyinga district: Rubagano (28), Mwakiro (42), and Bonero (24). These meetings are opportunities to collect data from communities and result from CBDC activities are: (a) Number of pills distributed: 136; (b) Number of condoms distributed: 22,632; (c) Number of household visited: 14,721; (d) Number of sensitization session organized: 2,466; and (e) Number of people reached during sensitization sessions: 50,056.

Organized Integrated Mobile Clinic on family planning, malaria, nutrition and HIV activities in Gitobe health center area:

The activity had been prepared in collaboration with CHWs, local administration, health providers, district supervisors and IHPB staff. This activity took place at the fundamental school of Rungazi in Gitobe commune. One hundred people had been sensitized on the importance of family planning - five people accepted Depo-Provera injectable.

Progress and discussion on FP indicators

Indicator	Target FY2016	Contribution of each method to couple year protection with available data up to date (from october2015 to May 2016)				
		Oct-Dec 2015	Jan-March 2016	April 2016	May 2015	Total
2.0.1. Couple Years Protection in USG supported programs (USAID 3.1.7.1-1)	136,828					77,179.04 (56%)
- pills		1,651	1,923.08	657.08	635.62	4,866.77
- injectables		11,668	12,721	4,429.25	4,423	33,241.25
- condom		241.71	255.65	126.59	103.06	727.02
- IUD		1,022	2,698	889	2,247	6,856.50
- Implant (Jadelle)		8,466.50	11,651.50	4,749.50	5,390	30,257.50
- Male sterilization		290	20	100	10	420
- Female sterilisation		190	440	90	90	810
Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services (USAID 3.1.7.1-3)		61%	59.9%	58.4%	54.3%	

Couple Years Protection in USG supported programs

This indicator is reported annually. Each method distributed is expected to contribute to increase couple year protection with a specific coefficient. If we consider the number of contraceptive methods distributed up to May 2016, we are at 56% of the target for the couple year protection (77,179 /136,828). Note that we did not have data for June. During the reporting period, we noticed that there were many cases of removal of implant (2,722) and IUD (422) due to rumors and misconception related to modern contraceptive method. The strategy implemented is to strengthen the community based distribution of contraceptive through which FP messages and information are given by community health workers.

Percent of USG-assisted service delivery sites providing family planning (FP) counseling and/or services.

In the intervention in May 2016, 54.3% of facilities (public, private, faith-based) deliver counseling and/or contraceptive methods.it looks like if there was a decrease from October 2015.The indicator is calculated considering health facilities reporting of methods distributed while we include faith based facility which do not offer modern methods. With the objective to reach 37%(add 5%) at the end of project, we have already added 22.3% to the baseline of 32%.

HIV/AIDS Strategy

Planned for April-June 2016	Achievement and results	Comments
Conduct two one-day sensitization sessions of district hospitals workers per district hospital	Partially achieved; one sensitization session held in Kayanza and Mukenke District Hospital	Sensitization meeting for Gahombo, Musema planned for quarter July – September 2016
Train 30 HTPs on HIV counseling	Achieved; Training session organized in Kayanza Health province (50 HTPS trained	Post-test training shows improvements
Organize 5 outreach HTC sessions	Achieved; 9 outreach HTC sessions organized	Results indicate higher yield of HIV positive cases
Test 487 OVC and other members of their families for HIV through RBP+ grant	Partially achieved; 198 OVC and other members of their families tested	
Support 101 PMTCT sites to offer ARV to reduce MTCT of HIV	95 PMTCT sites supported to offer ARV	Target of 101 was an overestimate
Organize regular transportation of DBS and viral load samples	Ongoing; 261 DBS and 457 viral load samples transported	
Treat victims of SGBV	18 victims of SGBV received ARV prophylaxis	
Support services for OVC through RBP+ grant	Achieved; 2,276 OVC served April – June	
Establish 14 new ART sites		IHPB mentored the ART created in January-march period
Organize mentoring visits	Achieved; 25 ART sites newly established and mentored	
Support transport of 1,457 CD4 samples from health	1,817 CD4 cell count samples transported	

centers to district hospitals through in-kind grants(IKG)		

Conduct two one-day sensitization sessions of district hospitals workers per district hospital

In partnership with the directors of the district hospitals, IHPB supported health care provider sensitization sessions in Kayanza and Mukenke hospital with the objective to integrate HTC into inpatient wards (internal medicine, pediatric, gynecology and obstetrics, surgery) and outpatient units (adult and infant outpatient, emergency) so that populations can access more integrated and comprehensive services. A total number of 42 healthcare providers (19 male and 23 female) participated. For Gahombo and Musema district hospitals, sensitization meetings are planned for quarter July – September 2016.

Targeting potential zones with potential to show high yield of HIV infection and Organize outreach HTC sessions

In collaboration with the Kayanza and Kirundo provincial and district health offices, IHPB supported outreach HTC sessions in zones identified to have key populations at high risk of HIV infection (female sex workers and men who have sex with men), as well as among other groups with higher risk of HIV transmission (single mothers, separated couples, men and women with sexual multiple partners, waiters/waitresses). Of the 775 individuals (315 male and 460 female) that volunteered to be tested through this outreach, all 27 (9 male and 18 female) that were found positive were referred to an ART site. During the outreach sessions, 2,894 condoms (2,884 male and 10 female) were distributed.

Strengthen capacities of health workers

In partnership with the Kayanza Provincial/District health Bureaus and through IKGs, IHPB supported:
Two five-day training sessions on management of TB including TB/VIH for healthcare providers were conducted - attended by 81 participants (49 male and 32 female). "Directives national pour la prise en charge de la Tuberculose et les comordidites" was used for training.

Two five-day training sessions on HIV testing and counseling for HTP and health providers from the 3 districts hospitals in Kayanza were organized – 50 participants (31male and 19 female) were trained using the training module on integrating HIV testing and provider-initiated testing.

Test OVC and other members of their families for HIV through RBP+ grant

Through RBP+ grant and in partnership with health facilities, 198 OVC (104male and 94 female) were tested. Of the 15 that tested positive (4 male and 11 female), were referred to health care and ARV treatment in different health facilities.

Support PMTCT sites to offer ARV to reduce MTCT of HIV

Through supervision visits, nurses have been assisted for introducing ARV prophylaxis in PMTCT program - 95 PMTCT sites (49 in Kayanza and 46 Kirundo) are operational. In addition, through in-kinds grants, IHPB supported operational expenses of health centers and districts hospitals (office supplies, fuel, per-diem, etc.) for better PMTCT quality services.

Organize routine transport of lab samples and lab results.

In partnership with Health Districts and through IKGs, IHPB supported transportation of DBS and Viral load samples from health facilities to the reference laboratory (INSP and or ANSS) and in return, transporting lab results from INSP and or ANSS to the health facilities – during the quarter, 261 DBS samples (52 in Kayanza and 209 in Kirundo), and 457 viral load samples (277 in Kayanza and 180 in Kirundo) were transported.

Treat victims of SGBV

IHPB supported health centers and districts hospitals to treat victims of rape. In total 18 victims of rape received ARV prophylaxis. Healthcare (PEP, HIV test and psychological support) for victims of SGBV is ongoing.

Support services for 2,448 OVC through RBP+ grant

Through RBP+ grant, IHPB served a total of 1,117 OVC (469 male and 648 female). Assistance includes school support, healthcare, juridical assistance, psychological assistance, hygienic kits and nutritional counseling. Specifically, the project: (a) paid school fees to 99 OVC of secondary school (47 male and 52 female), (b) provided health care support to 194 OVC (84 male and 110 female), (c) provided medical card to 1,306 OVC (632 male and 674 female), (d) provided nutritional counseling to 541 OVC (218 male and 323 female), and (e) provided hygienic kits (soap, towel, etc.) to 133 OVC (39 male and 99 female).

Establish new ART sites and organize mentoring visits

Through mentoring visits supported by IHPB, twenty-five ART sites (10 in Kayanza and 15 in Kirundo) created in the past quarter (January to March 2016) were strengthened during the period of April to June 2016. IHPB's support consisted of enabling nurses to prescribe and manage antiretroviral therapy (task shifting) as well as providing needed tools (protocol, data collection tools to these new sites. This approach permitted to increase the number of patients newly enrolled on ART. For example, during the months of April and May 2016, 317 people were enrolled in Kayanza (73) and Kirundo (244).

Support transport of 1,457 CD4 samples from health centers to district hospitals through IKGs

In partnership with Health Districts, IHPB supported the transport of CD4 cell count samples from health facilities to District Hospitals and also recovered and returned results to the facility level. During the period of April to June 2016, 2,178 CD4 cell count results (out of 1,457 planned) have been examined (Kirundo: 1817; Kayanza: 361. Patients with a CD4 cell count of 500 or less were initiated on ART, in accordance with the national protocol.

Progress and discussion on PEPFAR indicators

PEPFAR Indicators	Target FY 2016	Achievement					
		Oct-Dec 2015	Jan-March 2016	April	May	Total	% Achie-vement
Number of individuals who received	138,048	71,109	81,563	25,787	114,857	293,316	212%

PEPFAR Indicators	Target FY 2016	Achievement					
		Oct-Dec 2015	Jan-March 2016	April	May	Total	% Achie-vement
Testing and Counseling (T&C) services for HIV and received their results [PEPFAR HTC_TST_DSD]							
Number of HIV positive individuals	4,140	527	854	215	194	1,790	43%
Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery [PEPFAR PMTCT_ARV_DSD]	492	205	245	77	76	603	123%
Percent of infants born to HIV-positive women that receive a virologic HIV test done within 12 months of birth [PEPFAR PMTCT_EID	443	46	146	20	88	300	68%
Number of persons receiving post-GBV care (PEP, Post-rape care, other post-GBV care) [GEND_GBV]	18	30	26	11	7	74	206%
Number of HIV positive active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS (DSD)%	2448	639	1,431	366	456	1,939	79%
Number of HIV-infected adults and children newly enrolled in clinical care during reporting period who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load	4,124	-	1,129	146	105	1,380	33%
Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load [PEPFAR CARE_CURR_DSD]	8,435	-	7,389	7,031	7,064	7,064	84%
Number of adults and children newly enrolled on ART	3,723	140	852	220	97	1,309	35%
Number of adults and children receiving ART [current] (TA-only)	7,200	-	5,121	5,390	5,472	5,472	76%

Number of individuals who received HTC services and their test results

A total of 293,316 individuals received HTC services at eight-months of the fiscal year and the targeted population at the end of the fiscal year is 138,048. This represents a proportion of achievement of 212%. IHPB exceeded the target in FY16, thanks to the acceptability and quality of HTC.

Number of HIV positive individuals

The target for the fiscal year is 4,140 individuals who are tested HIV positive. Only 1,790 individuals tested positive for HIV over the eight months of the fiscal year, which is 43% of the targeted achievement and represents limited progress. IHPB is planning to initiate strategies that target people most likely to be infected by HIV i.e. outreach HTC sessions in hotspots, index-testing and provider-initiated testing and counseling for suspicious patients will be scaled up.

Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery

Eight-months through the fiscal year, 603 HIV-positive pregnant women are currently receiving antiretrovirals to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery. The expected results are 492, i.e. 123% of target. The results have exceeded the annual target, thanks to high client utilization and an effective integration of HTC in ANC services.

Number of infants who had a virologic HIV test within 12 months of birth during the reporting period

Expected results at the end of the year 2016 are 443 infants who had a virologic HIV test within 12 months of birth during the reporting period but the achievement to present is only 300 infants that is 68% of achievement. The progress at eight-month of the fiscal year is little due to weak system of follow up and the repetitive breakdown of PCR machine at INSP. Improving DBS collection and transportation as well as contracting a private lab will permit to achieve year 2016 targets.

Number of people receiving post-GBV care

The progress for this indicator exceeded the annual target (206%) at eight-months into the fiscal year. IHPB will continue to support the provision of care to GBV survivors at health facilities in the IHPB project zone.

Number of HIV-positive adults and children newly enrolled in clinical care

The objective of newly adults and children enrolled in clinical care is 4,124 at the end of FY 2016. Eight-months through the fiscal year, there are only 1,380 patients enrolled in care which makes 33% of achievement. Improving the "testing HIV+" indicator by strategies presented above will change the indicator on "number of HIV+ newly enrolled". To increase HIV service demand, IHPB will work with PLHIV network to refer all HIV positive persons in HIV care. In addition, support for ART decentralization will be continued in order to raise coverage in ART sites.

Number of HIV-positive adults and children who received at least one of the following: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD).

The progress is good (84%: 7,064/8,435) at eight-months through the fiscal year.

Number of adults and children newly enrolled on ART

The target for the fiscal year is 3,723 HIV infected patients newly enrolled on ART. Only 1,309 were put on ARV through May 2016, which is a 35% achievement of the annual target. This "below the target" progress is due to the fact of not finding enough HIV positive cases, weak coverage of ART sites and non-application of test and treat strategy. The scale-up of ART decentralization and implementation of the test and treat strategy in targeted provinces will produce greater results. In the other hand, strategies to find more people living with HIV in outreach HTC will contribute to enroll more positive individuals on ART.

Number of adults and children receiving ART [current] (TA-only)

The targeted result for FY 2016 is 7,200 adults and children currently receiving ARV in IHPB's provinces. Eight months through the fiscal year, the project achievement represents 76% of the target (5,472 adults and children on ART). This yield is going to be improved by the implementation of the test and treat strategy by September 2016.

Discussion and analysis of HIV/AIDS Performance Indicators Reference Sheet

The table below presents the progress on the indicators over the fiscal year:

HIV/AIDS PIRS Indicators	Target FY 2016	Achievement					
		Oct-Dec 2015	Jan-March 2016	April	May	Total	% Achie-vement
1.3.4 Number of persons receiving post-GBV care (PEP, Post-rape care, other post-GBV care) [GEND_GBV]	150	31	26	11	7	75	50% (75/150)
2.0.7 Number and percent of pregnant women with known status [PEPFAR PMTCT_STAT_DSD] 2.0.7	95%	89% (15,785/17,751)	90% (14,877/16,514)	88% (4,441/5,019)	88% (4,493/5,101		89% (39,596/44,385)
2.0.8 Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery [PEPFAR PMTCT_ARV_DSD]	95%	96% (205/213)	98% (240/244)	89% (77/87)	94% (76/81)		96% (598/625)
2.0.9 Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results [PEPFAR HTC_TST_DSD]	138,048	71,109	81,563	25,787	24,857	203,316	147% (203,316/138,048)

2.0.10 Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load [PEPFAR CARE_CURR_DSD]	8,435	7,030	7,389	7,055	7,125		84%
2.0.11 Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit [PEPFAR TB_SCREEN]	50%	47% (3,301/7,030)	59% (4,392/7,389)	61% (4,320/7,055)	54% (3,878/7,125)		56% (15,891/28,599)
2.0.12 Percent of infants born to HIV-positive women that receive a virologic HIV test done within 12 months of birth [PEPFAR PMTCT_EID	61%	22% (46/213)	54% (132/244)	20% (17/87)	114% (92/81)		46% (287/625)
2.0.13 Number of adults and children receiving ART [current] (TA-only)	7,200	3,808	5,121	5,398	5,488	19,815	76%
3.3.3 Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS [PEPFAR OVC_SERV_DSD]	2,488	639	1,141	366	458		

1.3.4 Number of persons receiving post-GBV care

The progress for this indicator is 50% at eight-months into the fiscal year. IHPB will continue to support the provision of care to GBV survivors coming in health facilities of the two provinces Kayanza and Kirundo.

2.0.7 Number and percent of pregnant women with known status

The target for this fiscal year is 95% and the achievement at eight-months is 89% (39,596/ 44,385). IHPB will continue to encourage health care providers for initiated-provider testing and counselling in order to test for HIV all pregnant women attending ANC.

2.0.8 Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery

The expected result for the fiscal year is already achieved: 96%. Efforts will be remained in order to provide antiretroviral prophylaxis to all HIV-positive pregnant women

2.0.9 Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results

A total number of 203,316 individuals received HTC services at eight-months of the fiscal year and the targeted population at the end of the fiscal year is 138,048. This represents a proportion of achievement of 147%. We exceed the target thanks to HTC acceptability and availability of HIV tests.

2.0.10 Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load

The progress is good (84%: 7,055/8,435) at Eight-months through the fiscal year. Strategies have been adopted such as immediate provision of cotrimoxazol to HIV-positive tested persons to enroll every people with HIV in care and improve the performance level. In the other hand, strategies to find more people living with HIV i.e. outreach HTC sessions in hotspots, index-testing and provider-initiated testing and counseling for suspicious patients will contribute to enroll more positive individuals in care.

2.0.11 Percentage of PLHIV in HIV clinical care who were screened for TB symptoms at the last clinical visit

The expected result for the fiscal year is exceeded (56%). Healthcare providers are increasingly aware of screening TB among PLHIV in care. Efforts will be remained for more progress.

2.0.12 Percent of infants born to HIV-positive women that receive a virologic HIV test done within 12 months of birth

The target for this fiscal year is 61% and the achievement at eight-months is 46% (287/625). This poor progress is due to temporally interrupts of the PCR machine at INSP. IHPB adopted strategy for reaching the target and had contracted a local private EID laboratory.

2.0.13 Number of adults and children receiving ART

The targeted result for FY 2016 is 7,200 adults and children receiving ARV in IHPB's provinces. Eight months through the fiscal year, the project achievement represents 76% of the target (5,472 adults and children on ART). This performance is going to be improved by the implementation of the test and treat strategy by September 2016. In addition, IHPB is implementing strategies that produce better yield of HIV-positive individuals i.e. outreach HTC sessions in hotspots, index-testing and provider-initiated testing and counseling for suspicious patients.

The scale-up of ART decentralization and implementation of the test and treat strategy in targeted provinces will produce greater results. In the other hand, strategies to find more people living with HIV in outreach HTC will contribute to enroll more positive individuals on ART.

3.3.3 Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS

Through RBP+ sub contract, expectations are to support 2,488 OVC. Active beneficiaries served in April and May month are 366 and 458 whose assistance is made of school support, Healthcare, juridical assistance, psychological assistance, hygienic kits and nutritional counseling. Support for OVC in need will continue through the end of the fiscal year.

Malaria Strategy

Planned for April-June 2016	Achievement and results	Comments
Support internship of CHWs on CCM of malaria and launch the strategy in Musema HD	Achieved	205 CHWs attended week long internship at their health center
Conduct 16 2-day refresher training of CHWs on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs	On track	Planned in July
Conduct three 4-day training sessions on CCM of malaria for health care workers in Kirundo (17), in Gashoho (15) and in Gahombo (15) HDs	17 health care workers from Kirundo trained in March 2016	Training for Gahombo is planned in July. For Gashoho, with supervision visits, there is no longer need of refresher training.
Support technical follow-up meeting on CCM of malaria with CHW, in-charge nurses and HPTs at HC and HH levels	Achieved	Activity planned every two months
Supply/furnish CCM of malaria equipment to CHWs in Gahombo, Kirundo, Gashoho and Kayanza HDs	Achieved	Activity planned every two months
Conduct HH visits to CHWs involved in CCM of malaria	Achieved	28 CHWs in Kirundo, 144 CHWs in Gashoho and 208 CHWs in

Planned for April-June 2016	Achievement and results	Comments
		Gahombo visited.
Conduct supportive supervision visits within HC to improve IPTp implementation, ITN distribution, case management and correct parasitological diagnosis	Achieved	26 health centers visited
Organize two 1-day workshops with religious leaders on the burden of malaria, and their contribution to sensitize people to malaria.	Achieved	235 religious leaders: (119: Giteranyi HD, 116: Muyinga HD, 35: Gashoho HD) attended
Support religious leaders to deliver monthly messages to congregations on malaria prevention, care and treatment	Achieved	23 Key messages developed by NMCP and reporting tool distributed.

Support internship of community health workers (CHWs) on Community case management (CCM) of malaria and launch the strategy in Musema health district (HD):

After completing training and before deploying to treat malaria at community level, selected CHWs in Musema HD undertook a five-day internship on CCM of malaria. These internships were conducted at each health center to orient these selected CHWs hon using rapid diagnostic tests (RDT), filling out registers and with community members coming to seek care.

Then, CCM of malaria implementation in Musema HD was officially launched in presence of communal administrative and health district authorities. This event was an opportunity to distribute the complete kit of CCM of malaria implementation to 208 CHWs.

Conduct three 4-day training sessions on CCM of malaria for health care workers in Kirundo (17), in Gashoho (15) and in Gahombo (15) HDs.

17 health care providers from Kirundo health district were trained on CCM of malaria. Training for Gahombo and Gashoho has been postponed due to preparations of the week dedicated for mother- child and trainings on other themes. Taking in account of the availability of pneumonia and diarrhea commodities, the training on CCM of malaria for Gahombo and Gashoho will be combined with training on community case management of pneumonia and diarrhea that is planned for July 2016.

Conduct 16 2-day refresher training of CHWs on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs:

This activity was delayed due to other activities planned by the Ministry of Public Health and Fight against AIDS (MPHFA) with health districts such as coordination meetings at district level, data validation in May and activities related to the week dedicated "to mother-child health" in July that mobilized health care providers and community health worker during 3 weeks. For Gahombo HD, IHPB expects to carry out this activity in August 2016. In Gashoho HD, the refresher training was estimated to no longer be necessary because main issues related to knowledge and skills in CCM of malaria implementation were satisfactorily improved upon during technical meetings described below.

Support technical follow-up meeting on CCM of malaria with CHW, in-charge nurses and health promotion technicians (HPT) at health center and household (HH) level:

Under the facilitation of health district supervisors, nurses-in charge and HPTs, IHPB supported two separate technical meetings (conducted every two months) on Community Case Management (CCM) of malaria that brought together 159 CHWs (63 female, 96 male) in Gashoho HD and one technical meeting in Musema that brought together 205 CHWs (96 male and 109 female).
The agenda of the meetings was initiated with the consent of health district team, and sought to improve the reporting on CCM of malaria, the calculation of average monthly consumption of malaria commodities, filling and holding tools, correcting and submitting monthly report.

For the two health districts, the main issue was that some CHWs (i) don't know how to correctly fill the register of malaria cases, the stock cards of gloves, (ii) forget to complete the individual form of tracking of sick child (*fiche individuelle de suivi de l'enfant malade*), and (iii) have also experienced stocks out of ACT (2-11 month) and of RDTs in April (Gashoho HD) and in May (Musema HD), ACT (1-5 years) and RDTs in June 2016 (Kirundo HD).

During these meetings, each supervisory team asked CHWs to share experience on how to address each of issues raised. The team then also gave a reminder on how to fill malaria case registers and how to hold stock cards. The supervisory team took advantage to correct monthly report of CCM of malaria and told to CHWs to order malaria commodities when only 5 blisters of each commodity in their stock remain.

IHPB, in collaboration with the Kirundo heath district team, distributed 400 kits of malaria rapid diagnostic tests (RDT) (each kit containing 25 tests) to 16 heath centers; two RDT kits per 200 CHWs (.
CHWs suggested to: increase the number of supportive supervision visits to once monthly, to reduce stock out of malaria commodities at health district level, and to provide to them adapted clothes. Malaria commodity stock outs at the health district may depend central level stockouts. To support a more consistent availability of malaria commodities, IHPB is following closely the status of stocks at district level and, if need be, avail malaria commodities (if available at central level), by providing logistic and technical assistance. Clothes are not part of the kit determined by the MPHFA.

Conduct household (HH) visits to CHWs involved in CCM of malaria.
In order to ensure storage conditions of malaria tools and commodities, health care providers and HPTs coordinated to carry out home visits to CHWs. These visits are opportunities to know the points of view of community members about services offered by CHWs. In Kirundo HD: 28 CHWs, Gashoho: 144 CHWs and Gahombo: 208 CHWs benefited from a household visit by health care providers and HPTs. At the same occasion, 13 community members met, appreciated services delivered by CHWs but unfortunately, they too deplored malaria commodity stockouts that sometimes occur; they also expressed demand for pneumonia and diarrhea treatment at the community level.

Supply/furnish CCM of malaria equipment to CHWs in Gahombo, Kirundo, Gashoho and Musema HDs.
In Musema HD where CCM of malaria should be scaled up, a complete kit[5] , (except RDT's and medication that are supplied by the health center) has been provided to 208 CHWs. In the other old

[5] Kit for CHWs to begin implementation of CCM of malaria: Registers of cases, referral and requisition book, iCCM module, box, padlock, solar lamp, bag, Jerri can, spoons, cup of 500 ml, safety box, box of 50 pairs of gloves, trash can, manual timer, algorithm and job aid for malaria care and use of rapid test diagnostic.

health districts with CCM of malaria, IHPB provided a stock of gloves for 3 months to each CHWs because, due to high demand for community-based malaria services, some CHWs use more than 50 pairs of gloves per month. Those gloves had been stored in health district's pharmacy and are to be delivered only to CHWs. During technical meetings, CHWs suggested to provide soap to ensure clean hands when taking care of sick children. In response to this need, IHPB bought and distributed 1 box of 24 pieces of soap to each CHW. The table below shows supplies and quantities distributed to CHWs during this quarter:

Health district	**Gloves (box of 50 pairs)**	**Safety boxes**	**Soaps (box of 24 pieces)**
Gahombo	726	242	242
Gashoho	486	-	160
Kirundo	771	-	257
Musema	624	208	208

IHPB specialist and supply chain specialist coordinated to send iCCM commodities that include 510 boxes (51,000 tablets) of Amoxicillin 250mg, 3920 boxes (392,000 tablets) of Zinc 20 mg and 20,000 sachets of oral rehydration salt for implementing iCCM in the four health district: Gahombo, Gashoho, Kirundo and Musema where iCCM will be expanded.

Conduct supportive supervision visits within HC to improve IPTp implementation, ITN distribution, and case management and correct parasitological diagnosis.

Using a supervision guide for malaria (developed by National Malaria Control Program, IHPB in collaboration with health district teams conducted supportive supervision visits to 26 health facilities in five health districts:

7 visits in Gashoho HD: Kagari, Gisanze, Musama, Kizi, Gashoho, Gisabazuba and Bwasare,

3 visits in Gahombo HD: Muhanga I, Muhanga II and Nzewe,

2 visits in Kirundo HD: Kirundo, Kigozi,

11 visits in Vumbi HD: 11 Vumbi, Gasura, Gikomero,Muramba, Nyamisagara, Ntega, Mugendo, Kinyovu, Mugina, Murungurira, Runyankezi, and

3 visits in Nyabikere: Nyaruhinda and Ruganira HC and Buhiga hospital.

These visits were focused on improving IPTp reporting and availability of Sulphadoxine Pyrimethamine (SP), integration of LLINs and SP administration during antenatal care (ANC) and respect of malaria treatment guidelines. In all health facilities visited, some of strengths were: availability of guidelines of malaria treatment, the consultation registers well filled. Weaknesses and challenges have been raised in some health facilities: the mismatch between recorded data and data in the register (Kagari, Gisanze, Musama, Gashoho and Bwasare); that the first dose of SP is not taken under observation of health provider (Bwasare, Gashoho, Musama et Gisanze); that clients don't receive explanation on how to take medication prescribed (Gashoho); and poor reporting on the consumption of anti-malaria drugs (Gisabazuba).

Supervisory teams took time to work together with each health facility team visited, by encouraging staff strengths. They talked about how to improve reporting and the quality of services delivered. The supervisory team considered the facility's challenges discussed with health care providers' technical

solutions to respond to challenges, such as: to avail water and jerrican in the antenatal care room, to analyze and summarize data progressively each week in a team of two persons, and to complete stock cards before beginning health facility's activities.
Also, jointly with USAID's Malaria Specialist, IHPB conducted visits to six (6) facilities in four health districts: Kirundo: 2 (Kirundo hospital and Kirundo HC), Vumbi: 1 (Vumbi HC), Kayanza: 1(Rugazi) and Giteranyi: 2(Giteranyi, Ngomo HC). Discussions during the visits focused on evolution of malaria cases, parasitological diagnosis, case management of malaria and availability of commodities at facility and community level. Comparing cases in April and May 2014, 2015 and 2016, the fact is that there is a high level of malaria incidence during that period every year. Considering the outbreak of malaria in February 2016, the data of monthly report, at health center, showed that the number of malaria cases have decreased from April 2016.

Participated in 4 coordination meetings

Coordination meetings were organized by the Direction de l'Offre et de la Demande des Soins (DODS) and the National Malaria Control Program (NMCP). With DODS, discussions focused (i)on mapping of iCCM partners, update on package they support and harmonizing of reporting template of iCCM activities-on(ii) expanding integrated community case management (iCCM) in heath districts where community case management (CCM) of malaria is being implemented.

As IHPB is engaged in child health, UNICEF committed to providing 51,000 tablets of Amoxicillin (250mg) 392,000 tablets of Zinc (20 mg) and 20,000 sachets of oral rehydration salt for implementing iCCM in the four (Gahombo, Gashoho, Kirundo, Musema) IHPB CCM of malaria HDs.

During the latest coordination meeting with the DODS, discussions focused on a review of an iCCM partners. In the coordination meeting realized by national Malaria Control Program, discussions focused on an assessment of quarter 1 achievements; sharing information on the situation of malaria cases from the period of outbreaks until April; stockouta of ACT (2-11 months, 1-5 years) due to the excessive consumption during outbreaks; and forecasts of malaria commodities for an eventual peak in May and in October 2016.

Organize two 1-day workshops with religious leaders on the burden of malaria, and their contribution to sensitize people to malaria.

Malaria is a big problem of health that affects everybody with a high level of vulnerability for pregnant women and children under five. To ensure a high level of community knowledge and to adopt good practices to fight malaria, IHPB organized a one-day sensitization workshop with religious leaders. The goal was to show, with malaria data at provincial and health district level, how malaria is a burden for health and for economy of households and thus to involve them to take part in activities related to fight.
In Muyinga Province, workshops were held separately per health district and brought together 119 religious leaders (114 male, 05 female) from Giteranyi HD, 116 (03 female, 113 male) from Muyinga HD and 35 (04 female, 31 male) from Gashoho HD.

After power point presentations done by health provincial director, health districts directors and NMCP staff, participants were dispatched in groups to commit on how they will act in fighting against malaria. Then they committed to deliver messages in each sermon and at the community level when they make

field visits within their congregations. Messages, described further below, will be related to seeking care early in case of fever, to using ITN as well as recommending to seek antenatal care early in pregnancy.

Support religious leaders to deliver monthly messages to congregations on malaria prevention, care and treatment.

A guide of 23 key messages was distributed to religious leaders and a reporting tool that should be submitted to their health center. IHPB, in collaboration with health districts supervisors shared this tool and key messages with health care providers during coordination meetings and called upon these last to coordinate with religious leaders.

Progress and discussion on malaria indicators

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec	Jan-Marc	April	May	Total
% of children under one year who had received LLINs through USG funds	95	84	96	95.54	91	91.40 **%**
% of pregnant women who had received LLINs during ANCs through USG funds	94	79.4	82.7	80.88	79.9	80.88 **%**
% of children under five with fever who received ACT within 24 hours of onset of fever.	75	84.51	76.12			68.6 **%**
% of pregnant women who received IPTp during ANC visit	60	48.3	71.66	78.3	78.4	64.57 **%**
number of health care providers trained on CCM of malaria/iCCM	77	0	17	30	0	**47**
number of community health workers trained on CCM of malaria	286	0	0	208	0	**208**
number of CHWs refreshed on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs	402	0	0	0	0	**0**
Number of health providers trained on new guidelines of malaria case management	201	195	0	0	0	**195**

% of children under one year who had received LLINs through USG funds:

IHPB accessed aggregated data from the National Health Information Management System (GESIS) database. Given that the level of achievement of this indicator up to date is 91.40% and the annual target set at 95%, the FY2016 target is being achieved.

% of pregnant women who had received LLINs during ANCs through USG funds:

The IHPB accessed aggregated data from the National Health Information Management System (GESIS) database. The level of achievement of the indicator is low: 80, 88% when the target at the end of the year is estimated at 94%. Within remaining quarter of FY16 (June to September), the target will be achieved.

% of children under five with fever who received ACT within 24 hours of onset of fever:

CCM of Malaria (PECADOM) is implemented in 4 health districts that including Kirundo, Gahombo, Gashoho and recently Musema. Considering the level of achievement until June 2016, i.e. 68.6% of children that received ACT within 24 hours of onset of fever, the annual target of 75% could be achieved. Low performance for this indicator is attributed to the malaria outbreak that contributed to stock out of ACTs during for a certain period of the reporting period.

% of pregnant women who received IPTp during ANC visit:

Given that the indicator achieved is 64.57%, it is surpassed the annual target of 60%. As shown in the previous table, the level of achievement during October-December 2016 is low. This period coincides with the start-up of the strategy in several IHPB districts.

Number of health care providers trained on CCM of malaria/iCCM:

In Kirundo HD, 17 health care providers were trained on CCM of malaria and in Musema health district: 30 health providers including 15 nurses, 5 health district supervisors, 5 health promotion technicians and 5 health provincial supervisors trained on iCCM (malaria, pneumonia, diarrhea and screening for malnutrition). 30 health care providers remained (15 from Gahombo and 15 from Gashoho) will be trained in July and August 2016.

Number of community health workers trained on CCM of malaria in Musema HD:

While all 286 CHWs in Musema HD benefited from the training on community case management of malaria, 208 CHWs[6] were been identified by a selection test to implement community case management (CCM) of malaria in Musema HD.

Number of CHWs refreshed on CCM of malaria and referral in Gahombo (242) and Gashoho (160) HDs:

IHPB planned to conduct a refresher training to 242 CHWs from Gahombo health district and 160 CHWs from Gashoho health district. This activity was delayed due to other activities planned by the Ministry of Public Health and Fight against AIDS, such as coordination meetings at district level and activities related to preparations of the week dedicated to mother-child heath in July that maintained health care providers and community health worker during 3 weeks. For Gahombo HD, that refresher training is planned in August 2016. In Gashoho HD, the refresher training is no longer necessary because main issues related to knowledge and skills in CCM of malaria implementation have been improved during technical meetings held every two months

Number of health providers trained on new guidelines of malaria case management:

In Y2, three health districts (Muyinga, Giteranyi and Gashoho) were trained on the new guidelines of malaria case management. During Y3, 201 health care providers from nine health districts (Gahombo, Kayanza, Musema, Kirundo, Vumbi, Mukenke, Busoni, Nyabikere and Buhiga) were targeted for training on the new guidelines of malaria case management. As such, 195 health providers were trained.

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[6] With the respect of what is stated in the guidance document on IMCI at community level: two to three CHWs per colline are required to implement IMCI at thecommunity level.

Planned for April-June 2016	Achievements and results	Comments
Conduct joint supervision of immunization	Achieved	
Support BDS to conduct three 5-day training sessions for 90 health care providers from Karusi and Kirundo on clinical IMCI	One session was conducted with 32 trainees in Karusi in December 2015	A Session for Kirundo is planned in July 2016
Conduct, two 5-day trainings for 92 health care providers from 45 health facilities in Kirundo Vumbi and Nyabikere health districts on the National Protocol of Malnutrition Management	One session was conducted with 37 trainees in Nyabikere in December 2015	Session for Vumbi is planned in August 2016
Conduct a post-training follow up with BDS for 27 health facilities	Conducted in Nyabikere in February 2016	

Conduct joint supervision on immunization

A joint supervision IHPB/District was conducted in five health centers identified as underperforming in MCH-related indicators in Gahombo health district: Nzewe, Gasenyi II, Ceyerezi, Kibaribari, and Ngoro. The supervision was conducted by two district supervisors and the IHPB technical program officer, the health center in-charge, and the health provider in charge of immunization service. The cold chain was analysed because in three health centers (Gahombo, Mubogora, and GasenyiI) refrigerators were no longer used because users claimed they were not functioning - observations revealed that the temperature inside the refrigerators varied outside a normal range, causing the risk of vaccines denaturation. A spare called *« CAROTTE »* was systematically replaced and a 3-day observation period was recommended. It was also recommended to assign a staff to monitor refrigerator functionality.

Training health care providers on management of acute malnutrition

In collaboration with the health district and the province offices, IHPB supported a 5-day training of health services providers from Buhiga health district. The trainees were: 15 health center-based nurses, 4 hospital-based nurses, 2 hospital-based medical doctors, one supervisor from BDS, and the medical chief od district Buhiga. The training was developed after a supervision conducted in the health facilities revealed a bad quality of acute malnutrition management: malnutrition screening is not systematic; there is also a lack of knowledge on how to classify malnutrition cases, as well as on how to provide nutritional education to target populations such as pregnant and breastfeeding women, and women with children under five. In addition, the absence of updated tools such as the protocol of acute malnutrition management and the weigh/length form was noted.

The training included the themes such as: nutrition concepts and factors influencing nutritional status; cycle of malnutrition-infection; causes and consequences of malnutrition; community component of acute malnutrition management protocol; screening of malnutrition; transport of severe malnutrition cases; outpatient: structure, admission, follow up and discharge; stabilization service for children aged 6 to 59 months: Admission, care and complications; stabilization services for children aged 0 to 6 months; nutritional supplementation service; and nutritional education.

The training began with a pretest and ended with a posttest with as results an average of 54% the score varying from 37.5% to 70 % in the pretest; and an average of 79%, the score varying from 52% and 77.5% in the post test.

Discussion and progress on CH indicators

Indicator	Target FY2016	Achieved to date FY 2016				
		Oct-Dec 2015	Jan-March 2016	April 2016	May 2016	Total
Number/percent of children who received DPT3 by 12 months of age	103,228	25,330	26,092	8,519	9,401	69,342
Number/percent of women reached with education on exclusive breastfeeding	115,000	41,743	41,726	12,814	18,485	114,768

Number/percent of children who received DPT3 by 12 months of age:

Data are daily collected in Immunization registers and forms, and reported monthly to the district on facility monthly reporting forms. The target for FY 2016 is 103,228; the achievement up to May 2016 is 69,342, representing 67% of the target. Trend shows that with the remaining time (June-September 2016) the target could be reached.

Number/percent of women reached with education on exclusive breastfeeding:

The indicator represents the number of women reached with education on exclusive breastfeeding conducted by community health workers through home visits and community meetings. The information is collected in CHWs monthly reports. The target for 2016 fiscal year is 115,000; the achievement up to May 2016 is 114,768 representing 99% of the target. With the remaining time (June-September 2016), the target will be surpassed. This is due to the fact that, the community component of IMCI and the community based management of malnutrition that were initially implemented in Kayanza and Muyinga provinces were extended to Nyabikere health district in Karusi province and Vumbi health district in Kirundo province.

Innovation study: Pilot of Integration of Prevention of Mother-to-Child Transmission (PMTCT) and Early Infant Diagnosis (EID) of HIV into Routine Newborn and Child Health Care

Planned for April-June 2016	Achievement and Results	Comments
Meetings with implementing partners (BPS, BDS, etc.)	Delayed	Meetings will start after required approval from ISTEEBU
Protocol submission to Burundi Ethics Committee	Achieved	Protocol approved by National Ethics Committee
Protocol submission to Ministry of finance and ISTEEBU	Ongoing	Protocol submitted and IHPB is waiting for statistics visa from ISTEEBU
Implementation and follow up	Delayed	It will start after obtaining statistics visa from ISTEEBU

The pilot study for the integration of PMTCT and EID of HIV into routine newborn and child healthcare was selected to be implemented during Y3. During this quarter, IHPB submitted the protocol and its appendices to the National Ethics Committee and obtained its approval and then submitted it to the Ministry of Finance and the Institute of Statistics and Economic Studies of Burundi (ISTEEBU). The following activities were achieved to accomplish these objectives:

Submit the protocol to the Burundi Ethics Committee
The Protocol and its appendices which were previously translated into French were submitted to the Burundi Ethics Committee. It was analyzed by the committee, who provided the approval to move forward.

Submit the protocol to the ISTEEBU
After approval by the Burundi Ethics Committee, the Protocol and its appendices were transmitted to the Ministry of Finance and the Institute of Statistics and Economic Studies of Burundi (ISTEEBU), who will issue the statistics visa authorizing the implementation of the study. It is currently under review.

Learning, Documentation and Dissemination

The focus of IHPB's April – June 2016 learning, documentation and dissemination has been to:
(1) Continue to document and disseminate information regarding IHPB project implementation and achievements:
(a) The published *Child Health Booklet on 7 practices of community component of IMCI* was disseminated;
(b) two newsletters, -one focusing on HIV/AIDS (Issue of May 2016) and another focusing on Maternal, Newborn and Child Health (issue of June 2016) were produced (one newsletter is already published and one is still in the refining process);
(c) Document two success stories on the impact of the incubators at Kirundo hospital, two success stories on the successful implementation and results of IPTp in Nyabikere health district and, finally, one success story on the impact of the training on Essential Obstetric and Newborn Care (EONC).

(2) harmonize a communication and documentation strategy following PTQA recommendations: The communications officer (a) Visited two IHPB Field Offices and discussed with Field Office Managers in Kirundo and Muyinga to identify communication and documentation related gaps, fetched recommendations and reported to the IHPB managing team, as well as considered these recommendations for year 4 planning;
(b) Started brainstorming and listing year 4 communication and documentation activities, after interesting discussions, training workshop and recommendations on producing and disseminating more informing-and-integrated communication products, on mainly the IHPB crosscutting areas such as SBCC, QI and Gender.

Program Monitoring & Evaluation

Planned for April-June 2016	Achievement and results	Comments
Conduct quarterly PEPFAR and project reporting	Achieved	

IHPB prepared and submitted the PEPFAR semi-annual report through DATIM (April 2016) in a timely manner. In addition, the contractual January-March 2016 quarterly report was submitted on time (April

29, 2016) and monthly progress reports (April, May, and June 2016) were submitted no later than the second working day of each following month.

In addition to routine M&E activities, with support from seven FHI 360 and Pathfinder staff, IHPB conducted a two-week Program and Technical Quality Assessment (PTQA). The PTQA objective was to collaboratively explore and identify essential means to strengthen the project management and technical quality of the IHPB project. Specifically, the PTQA exercise helped to identify the project's greatest management and technical strengths; identify the project's highest priority project management and technical challenges and opportunities of improvement; and develop a program and technical quality improvement plan (PTQIP) that readily addresses the project's highest priority challenges and needs and promotes its greatest strengths over the next 12 months. The report is being finalized and key findings will be shared with stakeholders.

As part of the PTQA recommendations, IHPB conducted a three-day working session of the M&E Technical Officers in order to improve their understanding of the Performance Indicator Reference Sheets (PIRS) and updated the Performance Monitoring and Evaluation Plan accordingly.

Program Management

Planned for April – June 2016	Achievement and results	Comments
Recruit and post additional staff as necessary	COP identified and hire after obtaining USAID approval	COP scheduled to report to duty in July 2016
Submit monthly, quarterly, and annual reports	Achieved	3 monthly and one quarterly reports submitted
Bujumbura-based staff conduct support visits to sub-offices	Achieved	
Hold quarterly staff planning and management meetings	Achieved	
Prepare for and convene Program and Technical Quality Assessment (PTQA)	Achieved	PTQA conducted with in-country support from 5 FHI Home Office and 2 Pathfinder staff
Participate in collaboration, coordination and partnership-building meetings at the national and field office levels	Achieved	

Recruit and post additional staff as necessary

During the quarter, FHI 360 identified a Chief of Party (COP), and negotiated salaries. After obtaining USAID concurrence, the COP scheduled to be in-country for duty in late July 2016.

Submit monthly, quarterly, and annual reports

During the reporting period, as required by the IHPB contract, FHI 360 submitted monthly progress reports for the months of April, May and June 2016 and January – March 2016 quarterly report. The monthly and quarterly reports present achievements during the report period.

Bujumbura-based staffs conduct support visits to sub-offices

Senior staff including the DCOP, Senior Leadership Team members, and other technical specialists and advisors conducted support supervision visits while key project activities were underway: trainings on CCM of malaria, QI/QA and integration; strengthening capacity of community structures; basic emergency and neonatal care; modern contraceptive technology; building capacity of civil society organizations; and other trainings.

Hold quarterly staff planning and management meetings

Under the leadership of the Deputy Chief of Party, the five-member Senior Leadership Team (Deputy COP, Associate Director of Finance & Administration), the Senior Technical Advisor of Health Systems Strengthening, the Senior Technical Advisor of Monitoring and Evaluation, and the Integrated Services Advisor held regular weekly meetings to make strategic decisions and monitor program implementation including coordinating with USAID, GOB entities and other USG partners. Under the leadership of a Field Office Manager, technical teams also held regular meetings with their respective staff in their respective offices.

Prepare for and convene Program and Technical Quality Assessment (PTQA)

With support from four FHI 360 and two Pathfinder Home Office staff, during the quarter, IHPB conducted an intensive two-week PTQA in May 2016. The following technical areas were assessed:
HIV Clinical Care & Prevention of Mother-to-Child HIV Transmission (PMTCT) services,
Maternal, Neonatal & Child Health (MNCH),
Malaria,
Reproductive Health (RH) & Family Planning (FP) services,
Quality Assurance/Quality Improvement (QA/QI),
Health Systems Strengthening (HSS),
Provincial-Based Management System,
Human Resources for Health/Supply Chain Management (HRH/SCM),
Monitoring & Evaluation (M&E), and
Project Management.
The PTQA mission was led by technical experts from FHI 360 Global Health, Population and Nutrition (GHPN) and program management experts from Platform and Portfolio Management (PPM), in close collaboration with IHPB leadership and staff in country and Pathfinder International staff from other programs. An intensive two-week country visit was convened in May 2016 for the assessment of all aforementioned components. The report is being finalized and key findings will be shared in due course.

Participate in collaboration, coordination, and partnership-building meetings at the national and field office levels

During the reporting period, IHPB fostered collaboration and coordination with USG-funded projects and organizations and MPHFA. The table below presents key events and meetings attended by project staff.

Date	Title of IHPB Staff Member	Theme of Meeting/Event
April 20, 2016	Malaria Specialist	Coordination meeting organized by National Malaria Control Program (NMCP)

Date	Title of IHPB Staff Member	Theme of Meeting/Event
April 29, 2016	Capacity Building Advisor	Celebration of the ninth day of global fight against malaria
May 4, 2016	Capacity Building Advisor	Meeting on the health book mother-child leaded by the Direction of Demand and Delivery care in the Ministry of Public Health
May 10, 2016	Malaria Specialist	Coordination meeting organized by Direction de l'Offre et de la Demande des soins (DODs)
May 11 - 13, 2016	MH specialist	Regional workshops on maternal death surveillance organized by PNSR
May 17, 2016	Director of HSS at FHI360 HQ; Senior Program Officer, Platform and Portfolio Management at FHI360 HQ; IHPB DCOP; IHPB Capacity Building Advisor	Audience with the Minister of Public Health and Fight against AIDS on the PTQA objectives and results
May 30 - June 9, 2016	MH specialist and Muyinga FOM	Training of trainers on SGBV organized by BRAVI in partnership with PNSR
June from 6 to 10, 2016	Integrated Health Services Advisor	Workshop for adaptation of new WHO 2015 guidelines on prevention and treatment of HIV infection
June 8, 2016	Malaria Specialist	Coordination meeting organized by Direction de l'Offre et de la Demande des soins (DODs)
June 13, 2016	Acting COP; M&E Specialist; Integrated Health Services Advisor.	USAID implementing partners meeting
June 13, 2016	Capacity Building Advisor	Workshop on the implementation of the 'Linkages Project'
June 24, 2016	Malaria Specialist	Coordination meeting organized by Direction de l'Offre et de la Demande des soins (DODs)

Problems Encountered/Solved or Outstanding

Achievements noted during the quarter can be attributed to the close working relationships with the central and peripheral structures of the MPHFA; quality and timely remote and in-country technical assistance from IHPB home office staff; and timely response to IHPB requests by USAID. However, in achieving the planned activities, IHPB encountered challenges that include:

- Unavailability of PNSR staff for conducting support supervision on BeMONC.
- Conflicting priorities of the MPHFA, such as the mother and child health week and the malaria epidemic control prevented the organization of certain training activities and learning sessions and limited the number of coaching visits.
- Stock out of reagents for early infant diagnosis (EID) and reliance on private laboratories.
- Unavailability of district teams due to competing district priorities.

Annex I: HIV/AIDS Strategy: Progress on PEPFAR indicators over the period October 2015 to May 2016

Indicators	Kayanza							Kirundo							TOTAL		
	Target FY 2016	Oct-Dec	Jan-March	April	May	Total	% achie-vement	Target 2016	Oct-Dec	Jan-March	April	May	Total	% achie-vement	Target 2016	Achei-vement	% Achie-vement
Number of individuals who received HTC services and their test results	92,939	37,286	43,764	15,902	14,853	111,805	120%	45,109	33,823	37,799	9,885	10,004	91,511	203%	138,048	203,316	147%
Number of HIV positive individuals	2,600	126	139	48	44	357	14%	1,540	401	715	167	150	1,433	93%	4,140	1,790	43%
Number of HIV-positive pregnant women who received antiretroviral to reduce risk of mother-to-child-transmission (MTCT) during pregnancy and delivery	125	50	51	22	17	140	112%	367	155	194	55	59	463	126%	492	603	123%
Number of infants who had a virologic HIV test within 12 months of birth during the reporting period	112	34	62	14	24	134	120%	331	12	84	6	64	166	50%	443	300	68%
Number of people receiving post-GBV care	18	13	9	7	4	33	183%	18	17	17	4	3	41	228%	36	74	206%
Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS (DSD)%								2,448	639	1,431	366	456	1,457	60%	2,448	1,457	60%
Number of HIV-positive adults and children newly enrolled in clinical care during reporting period who received at least one of the following at enrollment: clinical assessment (WHO staging), CD4 count, OR viral load	2,640	-	258	36	24	318	12%	1,484	-	871	110	81	1,062	72%	4,124	1,380	33%
Number of HIV-positive adults and children who received at least one of the following during the reporting period: clinical assessment (WHO staging) OR CD4 count OR viral load (DSD)	4,705	-	2,730	2,737	2,748	2,748	58%	3,730	-	4,659	4,294	4,316	4,316	116%	8,435	7,064	84%
Number of adults and children newly enrolled on ART	2,335	43	189	46	27	305	13%	1,388	97	663	174	70	1,004	72%	3,723	1,309	35%
Number of adults and children receiving ART [current] (TA-only)	4,016	-	2,210	2,245	2,266	2,266	56%	3,184	-	2,911	3,145	3,206	3,206	101%	7,200	5,472	76%

Annex II: HIV Positive yield in hotspots

Date	Hotspot	# participants			# counseled and recuperated results			# HIV positive tested		
		M	F	**Total**	M	F	**Total**	M	F	**Total**
3/5/2016	Runanira I et II	0	37	**37**	0	37	**37**	0	1	**1**
4/5/2016	Gatete	26	31	**57**	26	31	**57**	0	2	**2**
12/5/2016	Site Vumbi	16	40	**56**	14	35	**49**	0	0	**0**
28-30/06/2016	Ruhehe/Kimena	103	99	**202**	103	99	**202**	0	1	**1**
29/06/2016	Gatete	37	17	**54**	37	16	**53**	0	0	**0**
29/06/2016	Vumbi	38	62	**100**	38	62	**100**	2	6	**8**
29/06/2016	Marembo	42	58	**100**	41	58	**99**	1	1	**2**
29/06/2016	Kireka	34	42	**76**	34	42	**76**	3	3	**6**
30/06/2016	Kirundo center	22	80	**102**	22	80	**102**	3	4	**7**
TOTAL		318	466	**784**	315	460	**775**	9	18	**27**

During the quarter April to June 2016, IHPB organized nine outreach HTC sessions in hotspots. 784 persons participated to the sensitization for HIV testing with 99% (775/784) of acceptance of HIV testing and HIV positive yield of 3% (27/775) in hotspots.

Annex III: Success stories

Premature triplets` lives have been saved thanks to IHPB donated incubators at Kirundo Hospital

"Without the incubators, IRIHO wouldn't be today",
said Eric, the father of triplets whose lives have been saved at Kirundo hospital

In an exclusive interview, the IHPB Communication Officer spoke with a couple who was blessed with triplets. Harerimana Renate, - a 26-year old young woman and her partner Eric, of the living in the Busenyi, sub-colline of Kirundo Commune, in Kirundo health District. With a satisfied tone of voice, Renate uttered: "*I stayed [at Kirundo hospital] and doctors attended to me every day. [When] I started having pain and contractions, the head doctor said there was no more time to wait and brought me to the delivery room. In a few minutes, my triplets were delivered. One of them was brought straight to the neonatal intensive care room."*

Renate remembered: *"There were many premature babies in the incubators… only one was empty."*
She also confided: "*My child spent 26 days in the incubator. At first, I was hopeless, and feared that my child would die… but in the following weeks, my child had begun to make movement and this was quite a relief to me."*
Nodding to what his wife was saying, Eric added: "*Without the incubators, IRIHO wouldn't be with us today."*

Renate appreciates the support and care she got from Kirundo Hospital: *"I appreciate doctors and all the medical staff at Kirundo hospital, for their patience, kindness, openness, help, support, encouragement ... they have been a blessing to us with their care. I wish I would be able to bring back the children at the*

hospital to show them how my children have improved today."

The health of two mothers has improved thanks to Intermittent Treatment of Malaria (IPTp)

Nyabikere HD is among other districts experienced a malaria outbreak in recent months. According to reports from the Health Centre, among 2337 pregnant women who attended curative consultations in the period 2013-2016 only 432 were tested malaria positive (average of 18.5%) with a gradual reduction from a year to another as these figures show: 175 pregnant women had malaria over 628 came curative consultations in 2013, 128 over 922 in 2014, 84 over 787 in 2015, 36 over 322 in May 2016 (in only 5 months).

It`s towards achieving reduced malaria vulnerability for pregnant women that IHPB supports the efforts of the Ministry of Public Health and Fight Against HIV/AIDS (MSPLS) and, especially Nyabikere HD among other districts. Much effort and actions are jointly invested to significantly reduce the virulence of malaria for pregnant women through IPTp with SP.

IHPB teams and District supervisors carry out joint training supervision visits. It was at the end of a supervision visit that the IHPB Program Technical Officer in Nyabikere, together with the Communication and Documentation Officer, met two wonderful women with very wonderful stories, a visible evidence of the success of the IPTp.

RUGANIRA, PROVINCE KARUSI -Nkurunziza Dorine is a 34-year-old woman. She lives with her husband and 5 children on Ruganira hill in Nyabikere health district (HD).

You look pretty young… with already 5 children. Have you ever suffered from malaria during your previous pregnancy experience?

At the start of my first pregnancy, I had several bouts of malaria. I was not hospitalized during the first pregnancy, but suffered from malaria several times ... more than three times. At my second pregnancy, I was hospitalized twice. And so it was for my third child: twice I was hospitalized. During my fourth pregnancy, once I was very sick and hospitalized due to malaria.

Do you see any difference with your last pregnancy experience?

My surprise was that I never was weakened or have suffered from malaria all my last pregnancy period.

What might be the reason the reason for you?

I believe this is related medications that nurses have begun giving to us against malaria since the time I attended ANC. I think that is the reason…, because I cannot understand how I did not contract malaria, even once, given my past pregnancy experience. Today, thanks to these drugs I have been given each three months, I never felt sick from malaria.

Would you tell us what are those drugs you talking about?

"SP. Those drugs are called SP, if I remember well," she replied with a smile.

Can you tell us a little more of your experience with your last pregnancy?

I went for my first pregnancy test in the month of December 2015 when I realized that a child was already moving in my belly. I had not previously realized I had conceived. The nurse received me and gave me

advice, and additionally gave me SP, three tablets in total, to swallow in front of him. He told me to come back after a month. When I returned, he gave me again another three tablets advising this would make me less vulnerable to malaria. I came back at the health facility 4 times and took the medication each time. It was such a miracle for me not to contract malaria during pregnancy, for the first time.

My child was born on April 2, 2016, and he is doing very well. I can see the difference with other children. For instance, during my first pregnancy, I could not spend a month without falling ill with malaria. I would use mosquito nets but it did not help. I remember that I was obliged to bring my second child back to hospital a week after his birth due to malaria. The other siblings were also very weak since their birth, and very often used to fall sick. If I consider even the weight my newborn was after only two weeks of birth, it`s unbelievable. Really impressive. He`s already grown from 2.8 kilos to 3.5 kilos.

RUGANIRA, PROVINCE KARUSI -Havyarimana Mediatrice is 28 years old and experiencing her third pregnancy.

As she was leaving the ANC, she approached the IHPB team as they conducted an interview with her neighbor Dorine

At the end of Dorine`s interview, she started confiding out to us: "I was so vulnerable, weak and frequently contracted malaria during my first pregnancy. I was hospitalized every two months. I could not do anything, even the simplest household tasks. Each time, I would try to do small household work, I would get tired and fall sick from malaria. " she told our team.

Mediatrice continued: "With my second pregnancy, I was always sickly. I was hospitalized several times. But with this last pregnancy, as I speak I have not yet contracted malaria. "

Would you tell us how you feel now compared to your previous pregnancy experience?

"With my pregnancy, I am very fit, don`t you see? " said Mediatrice with satisfaction. “I feel well and stronger.” Evoking her pregnancy experience, she goes: "I think that following my weakness, my first child remained low weight up to five years of age. One day, he had had malaria, up to the point of convulsions and coma. I thought I would lose her. In general, my first two children are often weak and attract malaria easily, even though I manage cover them under a mosquito net. I hope to keep having a good experience with my current pregnancy because I already can feel the difference. "

Can you remember the age of your pregnancy and when you have started to take Fansidar?

" I don`t know. I don`t remember very well when I got pregnant. But I've been here at the hospital and have swallowed twice medication to prevent malaria. I will have to come back next Tuesday for my third dose with SP. "

So you have not yet contracted malaria since you got pregnant?

"I haven`t had a single sign of malaria.", she responded, her voice content.

What would you recommend other pregnant women like you?

"I would encourage pregnant women to take advantage of preventing malaria with Fansidar, as prescribed by doctors because they are very important. I would ask them, -given my sad previous experience of vulnerability to malaria during pregnancy, to take the doctor's advice to take Fansidar. "

Any additional thing you would like to say?

"Of course. I would wish to advocate for the availability for this medication for all. The IHPB should continue to support for our health facility meet their necessary needs in drugs." As she closes, she adds: " For my part, I am even ready to buy these medications from the pharmacy because they are important. "

Annex IV: IHPB Indicators – Achievements for the period October 2015 – June 2016

PMEP No	Indicator	Data Source	Collection Method	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016
1.2.1	Percent of supported facilities that experienced a stock-out at any point during the last three months [MR]	Facility Monthly Report	Document review / HIS database review	Quarterly	62%	35%	64.6% (106/164)	64.3% (104/164)	39% (64/164)
1.2.2	Percent of USG-assisted service delivery points (SDPs) that experience a stock out at any time during the reporting period of a contraceptive method that the SDP is expected to provide [FP/RH 3.1.7.1-2]	SARA/Channel	Data will be extracted from SARA/ Channel (district level database)	Quarterly	37.6%	0%	28.2%(42/149)	4.1% (6/147)	6.1% (9/147)
1.3.4 [GEND_GBV]	Number of persons receiving post-GBV care (Post-rape care, other post-GBV care, PEP)	Facility records	Document review	Quarterly	102	150	31	26	27
1.3.5	Number of facilities that provide PEP to GBV survivors	Facility records	Document review	Quarterly	7	27	23	23	23
2.0.3	Number of individuals who were referred to and received other health and non-health services [MR]	Facility reports	GESIS analysis	Quarterly	7,137	18,200	6,913	4,389	4993
2.0.4	Number/percent of children who received DPT3 by 12 months of age in USG-Assisted programs [3.1.6-61]	Facility records	Document review	Quarterly	81.9% GESIS 2013	82%	16865	91.7% (16,719/18,231)	102.3% (18,655/18,231)
2.0.5	Number/percent of women giving birth who received uterotonics in the third stage of labor through USG-supported programs [3.1.6-64]	Facility records	Document review	Quarterly	0	7,765	56.2% (6,066/10,795)	78% (10,690/13,695	85% (12,006/14,122)
2.0.6	Number/percent of women reached with education on exclusive breastfeeding	CHWs monthly report	Document review	Quarterly	NA	115,000	41,743	42,363	48,701
2.0.7 [PEPFAR PMTCT_STAT]	Number and percent of pregnant women with known HIV status [MR]	Facility records	HIV database analysis	Quarterly	94% 127,306/135626	95%	89.7%(15,785/17,751)	90.1% (14,877/16,514)	87.5%[7] (13,048/14,906)

[7] Lower performance than previous quarter because throughout April 2016, sites in Mukenke District stopped tested assuming that available kits of Determine were deteriorated.

PMEP No	Indicator	Data Source	Collection Method	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016
2.0.8 [PEPFAR PMTCT_ARV]	Percent of pregnant women who received antiretrovirals to reduce the risk of mother-to-child-transmission (MTCT) during pregnancy and delivery [MR]	Facility records	Document review	Quarterly	93% 957/1028	95%	96.2%(205/213)	98.4% (240/244)	90.2% (219/246)
2.0.9 [PEPFAR HTC_TST]	Number of individuals who received Testing and Counseling (T&C) services for HIV and received their results	Facility records	Routine data	Quarterly	360,446	138,048	71,109	81,563	75,075
2.0.10 [PEPFAR CARE_CURR]	Number of HIV-infected adults and children who received at least one of the following during the reporting period: clinical staging or CD4 count or viral load	Facility/ Client records	Routine data collection	Quarterly	10071	8,435[8]	7030	7,389	7,179[9]
2.0.11 [PEPFAR TB_SCREEN]	Percent of HIV-positive positive patients who were screened for TB in HIV care or treatment setting	Facility records	Routine data collection	Quarterly	12,8%	50%[10]	47%(3301/7030)	59.4% (4,392/7,389)	67.9% (4,875/7,179)
2.0.12 [PEPFAR PMTCT_EID]	Percent of infants born to HIV-positive women that receive a virological HIV test within 12 months of birth	Facility records	Routine data collection	Quarterly	31% (314/1028)	61%[2]	21.6%(46/213)	54.1% (132/244)	62.2% (153/246)
2.0.13 [PEPFAR TX_CURR]	Number of adults and children receiving ART (TA only)	Facility records	Routine data collection	Quarterly	4996	7,200[2]	3808	5,121	5,701
2.0.14	IPTp2 under direct observation of a health worker	Facility records	Document review	Quarterly	NA7	70%	48.9% (10,192/20,853)	64.0% (30,405/47,502)	79.6% (19,640/24,659)
2.0.15	Proportion of pregnant women attending ANC who received ITNs	Facility records	Routine data collection	Quarterly	80.3% 116160/144739	94%	77.1% (17,858/23,164)	83.3% (19,350/23,212)	80.3%[11] (16,409/20,424)
2.0.16	Proportion of children under five with fever who received ACT within	CHW reports	Routine data collection	Quarterly	66.6% 20666/31060	75%	84.6% (28,324/33,482)	74.7% (25,150/33,676)	68.6%[12] (24,060/35,062)

[8] PEPFAR reduced coverage zone from 4 to 2 provinces

[9] 155 PLHIV were referred from Kirundo Hospital to Kagari HC in Muyinga province, 42 referred from Rubura HC to Mparamirundi HC in Ngozi Province, 53 lost-to-follow up, 5 deceased

[10] Performance Indicator Reference Sheet target for FY2016

[11] Performance is lower than last quarter when there was a malaria outbreak.

[12] There was a stock out of ITNs from mid-April through mid-June 2016.

PMEP No	Indicator	Data Source	Collection Method	Reporting Frequency	Baseline	Year 3 Target	Oct-Dec 2015	Jan-Mar 2016	April – June 2016
	24 hours of onset of fever								
2.0.16a	Proportion of children under five RDT positive who received ACTs						100.0% (28,324/28338)	97.5% (28,260/28,971)	99.9% (26,182/26,192)
2.1.2	Number of cases treated or referred by CHWs (Malaria, diarrhea, ARI, FP, malnutrition, iron for pregnant women) [MR]	CHW reports	Routine data collection	Quarterly	NA	62,000	26,486 5991	Treated 28,260 Referred 5,692	Treated 26,182 Referred 9,112
2.2.2	Percentage of HIV service delivery points supported by PEPFAR that are directly providing integrated voluntary family planning services [PEPFAR FPINT_STE]	Facility Records	Routine Data collection/HIV database	Quarterly	26% 45/173	63%	57% (53/93)	64.2% (61/95)	70.5% (67/95)
2.3.2	Percent of supported health providers, managers and CHWs who have demonstrated improvement post-training [MR]	Training reports	Document review	Quarterly	N/A	90%	94.3% (218/231) 89.3% (50/56) NA	HP : 96% (437/455) Managers :100% (64/64) CHWs : 94.8% (370/390)	Health providers 92.8% (259/279) CHWs : 99.5% (199/201)
2.3.5	Number of health care workers who successfully completed an in-service training program	Training records	Document review	Quarterly	NA	-	579	235	279
2.3.6	Number of community health/para-social workers who successfully completed a pre-service training program	Training logs	Document review	Quarterly	NA	-	0	390	201
3.2.1	Percent of facilities that maintain timely reporting [MR]	Facility reports	HMS (GESIS) analysis	Quarterly	95% 165/173	97.8%	100% (173/173)	100% (173/173)	100% (173/173)
3.3.3	Number of active beneficiaries served by PEPFAR OVC programs for children and families affected by HIV/AIDS [PEPFAR OVC_SERV_DSD]	OVC database	Routine Data Analysis	Quarterly	11,9358	2,488	639	1141	951